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ABSTRACT

This packet contains materials that constitute an introduction to issues of confidentiality and informed consent in therapy or educational placement. Procedural safeguards for special education assignment have been designed to ensure that parents are involved in decisions regarding the testing and placement of their child. Issues of informed consent enter as the rights of parents and children are considered. This packet contains: (1) an overview of confidentiality and informed consent issues; (2) a discussion of "The Confidentiality Dilemma"; (3) a discussion of "Minor Consent"; (4) an overview of some basic resources, including references, models, experts to consult, agencies and resource organizations, and Internet resources; (5) a sample digest from the ERIC system; and (6) an excerpt from "Overcoming Confidentiality Barriers in Human Services Collaboration for At-Risk Youth" by William E. Davis. (Concluding article contains 26 references.) (SLD)

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*From the Center's Clearinghouse ...**

An introductory packet on

Confidentiality and Informed Consent

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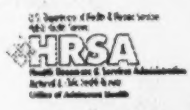

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- **enhance practitioner roles, functions and competence**
- **interface with systemic reform movements to strengthen mental health in schools**
- **assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools**

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1/14/98

Confidentiality and Informed Consent

I know it may be hard to talk about things that upset and worry you. To make it easier, I want you to know that most of what we talk about is private - just between the two of us. For instance, if you are feeling very sad or scared, it may help just to talk about how you feel. It will be safe for you to tell me about such feelings because I won't tell anyone what you said. Sometimes people feel very guilty about something they did and feel they can't tell anyone about it. We can talk about such things without anyone else knowing. Do you understand that it's OK to talk about most things here?

This Introductory Packet contains:

- Overview
- A discussion of : ***The Confidentiality Dilemma***
  Minor Consent
- A Quick Overview of Some Basic Resources
  - Selected References
  - Some Models for Dealing with Confidentiality
  - Consultation Cadre who are willing to help with issues related to confidentiality
  - A List of Agencies, Advocacy Groups and Other Resources
  - Internet Resources
- A sample ERIC Digest. ERIC Digests are brief research syntheses available from the ERIC Clearinghouses
- Article excerpt:
  Overcoming Confidentiality Barriers in Human Services Collaboration for At-Risk Youth (by William E. Davis, Ph.D.)

CONFIDENTIALITY*

Confidentiality is an ethical concern. The fundamental intent is to protect a client's right to privacy by ensuring that matters disclosed to a professional not be relayed to others without the informed consent of the client. In discussing confidentiality, therapists also hope to encourage communication.

Neither privacy nor confidentiality, however, are absolute rights, especially in the case of minors. There are fundamental exceptions, some involving ethical considerations and some involving legalities.

Privileged communication is a legal concept. It addresses legal rights protecting clients from having their disclosures to certain professionals revealed during legal proceedings without their informed consent. For example, 20 states fully or partly protect communications between school counselors and their pupil clients (Sheeley & Herlihy, 1987). Legal determinations regarding who is the client (e.g., whether minors or their parents hold the "privilege") and limitations on clients' rights to privileged communication are the bases for legal exceptions to maintaining confidentiality.

There are times when professionals would prefer to maintain confidences but cannot do so legally or ethically. Examples include instances when clients indicate an intention to harm themselves or someone else and when they have been abused. As a result of legislation, litigation, and ethical deliberations, professional guidelines call on interveners to breach the confidence and tell appropriate public authorities when there is a "clear danger to the person or to others" (American Psychological Association, 1981, p. 636). In this vein, but perhaps going a step further, the ethical guidelines for school counselors call for reporting instances when information provided by clients indicates circumstances likely to have a negative effect on others; that is, without revealing the identity of the client, the counselor is expected to report such circumstances "to the appropriate responsible authority" (American Association for Counseling and Development, 1981, p. 4). However , it is left to individual counselors to decide which circumstances are "likely" and what constitutes a "negative effect" that is serious enough to require reporting.

In order to adequately inform minors of exceptions to the promise of privacy, therapists must add a statement about exceptions, such as this:

> Although most of what we talk about is private, there are three kinds of problems you might tell me about that we would have to talk about with other people. If I find out that someone has been seriously hurting or abusing you, I would have to tell the police about it. If you tell me you have made plan to seriously hurt yourself, I would have to let your parents know. If you tell me you have made a plan to seriously hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can't. Do you understand that it's OK to talk about most things here but that these are three things we must talk about with other people?

* Excerpts from: Taylor, L. & Adelman, H. (1989). Reframing the confidentiality dilemma to work in children's best interests. *Professional Psychology: Research & Practice, 20*, 79-83.

Because youngsters may feel a bit overwhelmed about the exceptions to privacy and the serious problems described, they may simply nod their acquiescence or indicate that they are unsure about how to respond. To soften the impact, therapists may add statements, such as this:

> Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we'll also talk about the best way for us to talk about the problem with others. I want to be sure I'm doing the best I can to help you.

States vary in the degree to which their laws specify limitations on privileged communication between counseling professionals and minor clients. Some protect only disclosures about problems related to alcohol and other drugs. Others give broad protection, specifying a few exceptions such as reporting child abuse and crime or potential criminal activity. As far as professional psychology is concerned, however, the bottom line is that , "a gradual and continuous weakening has occurred in the confidentiality privilege" (Everstine et al., 1980, p. 836).

Undoubtedly, breaking confidentiality in any case can interfere with the trust between client and professional and make it difficult to help the client. Prevailing standards, however, stress that this concern is outweighed by the responsibility of the intervener to prevent various threats. In particular, matters such as suicide and assault on others (including physical and sexual abuse), which initially were defined as legal exceptions to privileged communications, have become established limits on confidentiality. As a result, the ethical task of informing prospective clients about all the exceptions and limits related to confidentiality has made the processes of ensuring privacy and building trust almost paradoxical.

Existing limits on confidentiality clearly reflect circumstances in which the society sees its interests as paramount and requires counselors to disclose what they learn even though the interveners believe it may hinder their efforts to help the client. The issues related to such limits are complex, controversial, and beyond the scope of this article. For our purposes, we can simply acknowledge that society always is likely to impose some limitations on privileged communication and that counselors always will find such limits troublesome.

Confidentiality as a Limitation on Helping

Concerns about protecting a client's right to privacy and exceptions to this right have been discussed thoroughly in the literature. Less attention has been paid to the fact that there are times when keeping information confidential can seriously hamper an intervener's efforts to help a client. The complexity of the ethical issues need not concern us here. We can simply take it as axiomatic that there will be times when interveners find it in the best interest of a minor client for others to know something that he or she has disclosed.

In its ethical guidelines on confidentiality, the American Psychological Association recognizes that there are instances when information obtained in clinical or counseling relationships should be shared with others. In doing so, the guidelines stress that such sharing should occur "only with persons clearly concerned with the case" (APA, 1981, p. 636). Given that teachers and parents are clearly connected and see themselves as also working in a minor's best interests, some interveners feel it appropriate-even essential-to discuss information with them. In other words, there are times when an intervener sees keeping a specific confidence shared by a minor client as working against the youngster's best interests and will evaluate the costs of not communicating the information

interests and will evaluate the costs of not communicating the information to others as outweighing the potential benefits of maintaining the minor's privacy.

Informed Consent

There was a time not so long ago when assigning students to special programs was done matter-of-factly. Most professionals believed they knew who needed help and what help was needed. It was a relatively simple matter to inform those involved that a problem existed and what was to be done. Growing awareness of rights and of the potentially harmful effects of treatment led to safeguards. Currently, consent is not taken for granted.

Parent and student involvement have become prominent considerations in designing screening, diagnosis, and placement practices in the schools. Parent organizations and child advocates have insisted that parents be involved in any decision that might have a profound effect on the course of a child's life. With respect to special education, this fact is reflected in the "procedural safeguards" associated with the passage of Public Law 94-142. These safeguards are rooted in the legal concept of due process as established in the Fourteenth Amendment to the federal constitution.

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. The special education procedural safeguards are meant to ensure that parents are involved in decisions regarding testing and placement of their child. That is, such interventions are not supposed to take place without parental consent.

Some of the safeguards spelled out in law are the following:

1. Parents must be notified whenever the school plans to conduct a special evaluation of their child.
2. Parents have the right to refuse consent for such an evaluation. (However, the school district has the right to a legal hearing to prove it is needed. Should parents want a special evaluation and the school refuses to provide it, parents can seek a legal hearing.)
3. Parents have the right to:
   - review the procedures and instruments to be used in any evaluation
   - be informed of the results and review all records
   - obtain an independent educational evaluation to be considered in any decisions
4. Parents must be notified whenever the school wants to change their child's educational placement, and they have the right to refuse consent for such a change. (Again, the school district can ask for a legal hearing to overrule the parents' decision; and parents who are unable to convince the school to provide the special placement they want can also seek such a hearing.)

All notifications and explanations are to be given in the parents' primary language or other primary mode of communication.

Levine (1975) enumerates the basic information that should be communicated and understood. These items include clarifying the purpose of the procedures (why the person is there; what the person will be doing), describing risks and benefits, spelling out alternatives, assuring the individual that participation is not required, and eliciting and answering all questions.

To make sure it is understood, such information may need to be presented in a variety of ways. Repeated verbal or written communications, translations, media presentations, question-and-answer follow-ups to evaluate whether information was understood, feedback from other consumers-all may be relevant at various times.

The emphasis on information, and the very term *informed consent*, may sometimes lead to greater emphasis on giving information than on ensuring true consent. As Biklen (1978) says of the term:

> It suggests that the key element of consent is the provision of information to people who are giving consent. Consent is a legal concept that has been referred to and implicitly defined in court cases and in legislation. It has three major aspects: capacity, information, and voluntariness. All three elements are equally relevant to any consent procedure or decision. Simply stated, one must have the ability to give consent in order to do so; one must have adequate information to do so in a knowledgeable way; and one must be free from coercion or any other threat to one's voluntariness. (p. 99)

Children's Assent

Young people's involvement in decision making is only beginning to be discussed seriously. For example, there is increasing discussion of the need to obtain the minors' assent in addition to parental consent.

Interest in civil rights in the late 1960s, and related advocacy of minors' rights in education and mental health, has led to greater consideration of the rights of children and adolescents to be involved in making decisions that affect them. Concomitantly, long-standing controversies have reemerged about the risks and benefits of young people's involvement in decision making and their competence to make appropriate decisions.

Consent

In a society that values fairness and personal liberty, consent is a very important concept. Such a society has a strong commitment to ensuring personal autonomy for everyone. Children and individuals with problems often are treated in ways that diminish their autonomy. This occurs because of assumptions about their relative lack of competence and wisdom. Even when they are treated autonomously, their decisions may not be respected.

The idea that autonomy should be respected has made consent not only a legal but also a major moral concern. The legal and moral mechanism for maintaining autonomy usually is designated *informed consent*. Six major functions served by the consent mechanism are the promotion of individual autonomy, the protection of clients or subjects, the avoidance of fraud and duress, the promotion of rational decisions, the encouragement of self scrutiny by professionals, and the involvement of the public in promoting autonomy as a general social value and in controlling professional practices and research.

The desirability of such outcomes seems evident. The problems and issues involved in appropriately eliciting consent have to do with such matters as: When is consent needed? When is it justified for one person to offer consent for another? Who decides when consent is needed and when one person can represent another? What information must be given in eliciting consent? How can anyone be certain that consent has been voluntarily given? Each of these questions raises significant dilemmas for professionals.

To highlight major concerns associated with the concept of consent, we focus on (1) competence and paternalism as they affect decisions about when consent must be elicited and from whom, and (2) the nature of relevant information and voluntary consent.

The Question of Competence and the Problem of Paternalism

Competence in the context of consent refers to the ability to understand (the ability to receive and process information, make decisions, and choose from among alternatives). Criteria for deciding about the adequacy of these abilities are difficult to specify. Usually very general criteria are established, such as age and mental status.

Children--and those diagnosed as mentally retarded, autistic, or psychotic--usually are seen as incompetent in a legal sense and in need of surrogates (parents, guardians, and courts) to give consent. However, the basis for deciding what constitutes competence and when others should act remains controversial. The example of children's consent illustrates just how difficult the problem is. At what age should it be necessary to ask a child's consent before involving the child in a psychological or educational intervention (including testing)? With certain school assessment activity, the legal answer is that no individual consent is needed from either parents or child through the age period when attendance is compelled by the state. With regard to special psychological testing, special class placement, and therapeutic treatments, the common answer is that only the parents' consent is needed, and in some cases not even their consent is sought.

The question of competence is strongly related to the problem of paternalism. It comes as no surprise that professionals, parents, government agents, and many others in society have opinions as to what is good for children. Such opinions backed by the power to impose them may lead to excessive paternalism.

For example, the professional who tests a youngster who does not want to be tested is confronted with this problem. It is a paternalistic act whenever a child is made to undergo unwanted assessment, even though the activity is viewed as in the child's "best interests." Whether stated or not, when such actions are taken, the child's autonomy is made less important than the possible harm to the child or others if the child is not assessed or the possible benefits to be gained if the child is assessed.

Relevant Information and Voluntary Consent

Whenever consent is to be elicited, relevant information must be provided and decisions must be made voluntarily. Relevant information must be provided in an understandable manner--a requirement that is difficult to meet when complex psychoeducational practices are used. Cultural and language differences also may be barriers in making information understandable.

Providing relevant information does not guarantee that consent is

given voluntarily. In many situations, consent is given because people feel they have no meaningful alternative. For example, children in special school programs and their parents may consent to additional assessment (therapy, medication, and so forth) because of fear that if they refuse they may be asked to leave the program.

When is voluntary consent needed? In addition to legal and ethical guidelines, voluntary consent is needed whenever the intent is to establish a helping relationship. Power relationships and situations in which influence is relied upon to elicit compliance do not involve the consent of participants. In contrast, helping relationships are based on voluntary consent. Thus, by definition, the obtaining of informed and voluntary consent defines whether the intent of an intervention is social control or helping.

When may consent be waived? The answer seems clearest when a problem is extremely threatening or an intervention is extremely unthreatening. For instance, persons who are seen as immediately dangerous to others or as unable to protect or care for themselves generally are accepted as likely candidates for waivers of consent.

Activities that are common to everyday living, such as much of the assessment and evaluation activity that permeates all our lives, provide another example. But they usually are not understood in terms of waived consent. They are, however, instances of de facto waived consent.

Although ethical concerns about waived consent are most likely to be raised in cases of extreme problems and dramatic interventions, consent that is waived in a de facto manner perhaps ought to be of equal concern. Many commonplace activities, such as routine achievement, intelligence, and interest testing in schools, can have life-shaping impact and are likely to have an effect on a large segment of the population. In instances in which consent is ignored, coercion is involved and needs to be justified.

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A Brief Discussion of:

THE CONFIDENTIALITY DILEMMA

(For a more extensive discussion of this topic, see L. Taylor & H. Adelman (1989). Reframing the confidentiality dilemma to work in children's best interests, *Professional Psychology: Research and Practice, 20,* 79-83.)

We all value client confidentiality. At the same time, we are aware of the legal responsibility to report endangering and illegal acts. Such reporting requirements naturally raise concerns about the negative impact on the counseling relationship.

> In reaction to what they see as an erosion or confidentiality, some interveners communicate only what the law compels. Others are so overwhelmed by reporting requirements that they turn the concept of confidentiality inside out. For example, a drug counselor recently stated:
>
> > *"I explained confidentiality: that if he told me anything about the possibility of hurting himself or anyone else or about taking an illegal substance I would have to tell others, including his parents and the authorities".*
>
> Concern for reporting so dominated him that concerns about protecting privacy and establishing trust were not addressed.

Clearly, there is a dilemma. On the one hand, an intervener must avoid undermining confidentiality and privileged communication; on the other hand, s/he must give appropriate information to others who share concern and responsibility for a minor's welfare. It is tempting to resolve the dilemma by reasserting that all counseling information should be confidential and privileged. Such a position, however, ignores the fact that failure to share germane information can seriously hamper efforts to help the client.

In working with minors, concerns about the limits on confidentiality may be best approached by reframing the problem and focusing on how to facilitate *appropriate* sharing of information. From this perspective, we have come to focus less on how to avoid breaching confidences and more on how to establish the type or working relationship where young clients take the lead in sharing information when appropriate. To these ends, we stress processes to enhance client motivation and empower them to share information when it can help solve their problems. In addition, steps are taken to minimize the negative consequences of divulging confidences.

Enhancing Motivation for Sharing

Informing clients about reporting requirements can compound negative attitudes toward intervention. Thus, there may be a need for systematic

efforts to enhance motivation to participate. The problem, of course, is a bit paradoxical: that is, how to elicit sufficient participation to allow the counselor to demonstrate that participation is worthwhile.

One strategy involves demonstrating to the client intrinsic payoffs for taking the risk of disclosing personal thoughts and feelings. We start with the assumption, born of experience, that first contacts allow sufficient access to encourage attendance for a couple of sessions. That is, we know that skilled therapists use a range of nonthreatening activities to help establish enough rapport that most youngsters are willing to return at least for a second session. The following ideas for enhancing motivational readiness build on this initial rapport.

Available theory and research suggest the place to begin enhancing motivational readiness to disclose is to find any area in which the client expresses a personal interest. These include areas of strength, success, or problems, reactions to being referred, and so forth. Sometimes the area is clear. For instance, some young clients, perhaps in an effort to feel more in control of the situation, lead the intervener away from the referral problem to talk about some other matter. In such cases, initially we follow their lead. Almost inevitably, once they start talking about their lives, they share some complaint or problem. Some act surprised about being referred. In these cases, we begin by sharing in a nonjudgmental way the concerns expressed by parents or teachers and then try to mobilize clients to share their perspectives (often they are very motivated to rebut what others have said). We find many who respond best initially to the structure or a question and answer format that explores areas of personal concern (e.g., instruments such as the Children's Depression Inventory). Structured interviews provide a useful framework to identify openly an area of concern that can be discussed to some extent.

> By identifying a problem the client expresses a personal desire to resolve and probably can resolve with some help, the intervener then is in a position to validate feelings and encourage exploration of cause and correction.
> For example,
>
> *"You feel like your teacher doesn't listen and treats you unfairly. I'll bet if we thought a bit about it, we could come up with some ways to make things better for you. Tell me what you've tried or would like to try, and then we'll figure out what to do."*

Once a mutual objective is established, the focus shifts to strategies for maintaining the client's motivation in working toward a solution. This, of course, involves ensuring that the client experiences a sense of satisfaction related to working with the therapist. From a motivational perspective, such satisfaction results from the type of (a) options and choices that enhance feelings of self-determination (e.g., perceived control) and (b) support, guidance, skill development, and feedback that enhance feelings of competence (e.g., self-efficacy).

Several problems may have to be worked through before a young client will disclose something perceived as risky. Hopefully, when the risk is taken, the matter is one that can be kept private. Whenever a matter is raised that must be shared, we suggest use of strategies that empower clients to take the lead in sharing the information with others.

Empowering Clients to Share Information

Empowerment of clients can be viewed as a defining characteristic and a primary aim of a helping relationship. That is, a fundamental concern of an intervener in offering a helping relationship is to act in the *best interests of the client, as defined by the client,* through an informed agreement about ongoing client participation in decision making about means and ends. The ultimate intent is to empower clients so they can independently pursue their best interests. To accomplish this, intervention focuses on enhancing a client's motivation and skills for autonomous functioning.

In contrast, socialization interventions give primary consideration to the *society's best interests.* Individual consent and decision making are not necessarily sought, and empowerment of the individual is pursued only if it is consonant with the socialization agenda. Fortunately, individual and societal interests often are in harmony. However, instances where confidentiality is limited by law are indicative of circumstances where individual and societal interests conflict and where society's interests predominate.

All of this has direct implications for the problem of divulging information when the intervener views this as in the client's best interests. In a helping process, the first responsibility of the intervener is to determine whether the client agrees that information should be shared. If the client doesn't agree, the intervener must be prepared to help the client explore (in a developmentally appropriate way) the costs and benefits involved. This may take some time, especially since the point is not to convince or seduce but to facilitate comprehension (e.g., understanding of the positive impact sharing can have on relations with significant others). In the end, the individual still may not agree, and the ethics of the situation may dictate that the intervener break confidentiality without consent.

If the client sees it in his or her interest to have others informed of certain matters, then discussion shifts to how this will be accomplished. Again, in keeping with a commitment to empowering the client, the client should be in control of what information is shared, and, if feasible, should be the one who does the sharing.

Ideally, helping and socialization come together as the counselor helps a client understand the value of relating positively to significant others (e.g., parents, teachers) with respect to sharing feelings, expressing needs, and working toward agreements.

Minimizing Negative Consequences of Disclosure

Whatever the benefits, divulging confidences can have costs (e.g., for the client and for others). Ethically and practically, the intervener must take steps to minimize these costs. For example, part of the problem may be reduced if, in explaining to the client the need for relating what has been learned, the client agrees that the case falls within the previously discussed limits on confidentiality, such as harm to self or others. The costs to the individual also may be reduced significantly in instances where it is feasible to share information without revealing the source's identity.

In general, when legal or ethical considerations compel an intervener to divulge confidences, three steps must be taken to minimize repercussions. Essentially, the steps involve (a) an explanation to the client of the reason for disclosure, (b) an exploration of the likely repercussions in and outside of the counseling situation, and (c) a discussion of how to proceed so that negative consequences are minimized and potential benefits maximized.

For example, in explaining reasons, one might begin with

> *"What you have shared today is very important. I know you're not ready to talk about this with your parents, but it is the kind of thing that I told you at the beginning that I am required to tell them."*

One might explore repercussions for the helping relationship by stating

> *"I know that if I do so you will be upset with me and it will be hard for you to trust me anymore. I feel caught in this situation. I'd like us to be able to work something out to make this all come out as good as we can make it".*

With respect to how to proceed, often it is feasible simply to encourage the client to take actions in keeping with his/her best interests or give consent to allow the counselor to do so.

> *"This may work best for you if you tell them -- rather than me. Or if you don't feel ready to handle this, we both could sit down with your parents while I tell them".*

Concluding Comments

Responsible professionals want to avoid both surrendering the confidentiality surrounding counseling relationships and overreacting to necessary limitations on confidences. In trying to combat encroachments on privileged communication, counselor's recognize that the assurance of confidentiality and legal privilege are meant to protect a client's privacy and help establish an atmosphere of safety and trust. At the same time, it is important to remember that such assurances are not meant to encourage young clients to avoid sharing important information with significant others. Such sharing often is essential to the client's personal growth. Indeed, it is by learning how to communicate with others about private and personal matters that clients can increase their sense of competence, personal control, and interpersonal relatedness, as well as their motivation and ability to solve problems.

A Brief Discussion of:

MINOR CONSENT

The following excerpts from Abigail English's introduction to *State Minor Consent Statutes: A Summary** provide an overview of ***The Legal Framework for Minor 'Consent'***

. . . . .The issues which arise most frequently in providing health care to adolescents who are minors fall into three specific areas:

1. Consent: who is authorized to give consent and whose consent is required?
2. Confidentiality: who has the right to control the release of confidential information about the care, including medical records, and who has the right to receive such information?
3. Payment: who is financially liable for payment and is there a source of insurance coverage or public funding available that the adolescent can access?

The Legal Framework

. . . . .delivery of adolescent health care has evolved in several significant ways. First, the courts have recognized that minors, as well as adults have constitutional rights, although there has been considerable controversy concerning the scope of those rights. Second, a growing number of states are enacting statutes to authorize minors to give their own consent for health care. Third, the financing of health care services for all age groups and income levels is undergoing major change . . . . .

In discussing ***constitutional issues***, the author states: Beginning with *In re Gault* in 1967, in which the United States Supreme Court stated that "neither the Fourteenth Amendment nor the Due Process Clause is for adults alone," the Court has held repeatedly that minors have constitutional rights. The *Gault* decision, which accorded minors certain procedural rights when they are charged by the state with juvenile delinquency offenses, was followed by others recognizing that minors also had rights of free speech under the First Amendment *(Tinker v. Des Moines Independent School District,* 1969), and that they had privacy rights as well *(Planned Parenthood of Missouri v. Danforth,* 1976, and *Carey v. Population Services International,* 1977). Although the Supreme Court subsequently rendered decisions which were more equivocal about the scope of minors' constitutional rights, the basic principles articulated in the early cases still stand.

The area of most frequent constitutional litigation--and to some degree the greatest controversy has been the rights of minors with respect to reproductive health care, particularly abortion. The *Carey* case clearly established that the right of privacy protects minors' access to contraceptives, while the history of constitutional litigation with respect to abortion has been more complex. Following the decision in *Danforth,* which held that parents do not have an arbitrary veto power with respect to the abortion decision of their abortion decision of their minor daughters, the Supreme Court decided several additional cases--beginning with *Bellotti v. Baird* in 1979 and culminating most recently with *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992--addressing parental notification and consent issues related to abortion. The import of these cases has been that while a state may enact a mandatory parental involvement requirement for minors' abortions it must also, at minimum, establish an alternative procedure, usually known as a "judicial bypass." In the

* Prepared by National Center for Youth Law (San Francisco, CA) in April, 1995 with M. Matthews, K. Extavour, C. Palamountain, & J. Yang as co-authors, for the Center for Continuing Education in Adolescent Health. 3333 Burnet Ave., Cincinnati, OH 45229-3039, (513)559-4681. 1

bypass proceeding a minor must be permitted, without parental involvement, to seek a court order authorizing an abortion: if she is mature enough to give an informed consent, the court must allow her to make her own decision and, if she is not mature, the court must determine whether an abortion would be in her best interest. . . . .

The author also highlights ***state and federal statutes***.

Consent

The law generally requires the consent of a parent before medical care can be provided to a minor. There are, however, numerous exceptions to this requirement. In many situations someone other than a biological parent -- such as a foster parent, a juvenile court, a social worker or probation officer--may be able to give consent in the place of the parent. Moreover, in emergency situations care may be provided without prior consent in order to safeguard the life and health of the minor. Most significant for the adolescent health care practitioner, however, are the legal provisions which authorize minors themselves to give consent for their care. These provisions are typically based on either the status of the minor or the services sought.

All states have enacted one or more provisions which authorize minors to consent to certain services. These services most frequently include: pregnancy related care; abortion, diagnosis and treatment for STDs, HIV disease or AIDs, and reportable or contagious diseases; examination and treatment related to sexual assault, counseling and treatment of drug and alcohol problems; and mental health treatment, especially outpatient care. Some of these statutes contain age limits, which most frequently fall between age 12 and age 15.

Similarly, all states have enacted one or more provisions which authorize minors who have attained a specific status to give consent for their own health care. Pursuant to these provisions, the following groups of minors may be authorized to do so: emancipated minors; those who are living apart from their parents; married minors; minors who are the parents of a child; high school graduates; and minors who have attained a certain age. Moreover, in a few states explicit statutes authorize minors who are "mature minors" to consent for care.

The Mature Minor Doctrine and Informed Consent

Even in the absence of a specific statute, however, "mature minors" may have the legal capacity to give consent for their own care. The mature minor doctrine emerged from court decisions, primarily state court decision, addressing the circumstances in which a physician could be held liable in damages for providing care to a minor without parental consent. Pursuant to the doctrine, there is little likelihood that a practitioner will incur liability for failure to obtain parental consent in situations in which the minor is an older adolescent (typically at least age 15) who is capable of giving an informed consent and in which the care is not high risk, is for the minor's benefit, and is within the mainstream of established medical opinion. In fact, during the past few decades diligent searches have found no reported decisions holding a physician liable in such circumstances solely on the basis of failure to obtain parental consent when non-negligent care was provided to a mature minor who had given informed consent. The basic criteria for determining whether a patient is capable of giving an informed consent are that the patient must be able to understand the risks and benefits of any proposed treatment or procedure and its alternatives and must be able to make a voluntary choice among the alternatives. These criteria apply to minors as well as adults.

Privacy and Confidentiality

There are numerous reasons why it is important to maintain confidentiality in the delivery of health care services to adolescents. Possibly the most important is to encourage adolescents to seek necessary care, but additional reasons include

supporting adolescents' growing sense of privacy and autonomy and protecting them from the humiliation and discrimination that could result from disclosure of confidential information.

The confidentiality obligation has numerous sources in law and policy. They include: the federal and state constitutions; federal statues and regulations (such as those which pertain to Medicaid, Title X family planning programs, federal drug and alcohol programs, Title V maternal and child health programs, or community and migrant health centers); state statutes and regulations (such as medical confidentiality statutes, medical records statutes. privilege statutes, professional licensing statutes, or funding statutes); court decisions; and professional ethical standards.

Because these varied provisions sometimes conflict, or are less than clear in their application to minors, it is important that practitioners have some general guidelines to follow -- or questions to ask -- in developing their understanding how to handle confidential information. Confidentiality protections are rarely, if ever, absolute, so it is important for practitioners to understand what *may* be disclosed (based on their discretion and professional judgement), what *must* be disclosed, and what *may not* be disclosed. In reaching this understanding, a few of the most relevant questions include: What information is confidential (since it is confidential information that is protected against disclosure)? What information is not confidential (since such information is not protected)? What exceptions are there in the confidentiality requirements? What information can be released with consent? What other mechanisms allow for discretionary disclosure? What mandates exist for reporting or disclosing confidential information?

In general, even confidential information may be disclosed as long as authorization is obtained from the patient or another appropriate person. Often, when minors have the legal right to consent to their own care, they also have the right to control disclosure of confidential information about that care. This is not always the case, however, since there are a number circumstances in which disclosure over the objection of the minor might be required: for example, if a specific legal provision requires disclosure to parents; a mandatory reporting obligation applies, as in the case of suspected physical or sexual abuse; or the minor poses a severe danger to himself or others.

When the minor does not have the legal right to consent to care, or to control disclosure, the release of confidential information must generally be authorized by the minor's parent or the person (or entity) with legal custody or guardianship. Even when this is necessary, however, it is still advisable -- from an ethical perspective -- for the practitioner to seek the agreement of the minor to disclose confidential information and certainly, at minimum, to advise the minor at the outset of treatment of any limits to confidentiality. Fortunately, in many circumstances, issues of confidentiality and disclosure can be resolved by discussion and information agreement between a physician, the adolescent patient, and the parents without reference to legal requirements.

Payment

There is an integral relationship among the legal provisions which pertain to consent, confidentiality, and payment in the delivery of health care services to adolescents. To the extent that an adolescent does not have available a source of free care or access to insurance coverage, provisions which purport to enable adolescents to give their own consent for care and to obtain it on a confidential basis do not actually guarantee access. It may seem implicit that if a minor is authorized to consent to care, it is the minor rather than the parent who is responsible for payment and, in fact, some state statutes explicitly so provide. In reality, however, few if any adolescents are able to pay for health care. Consequently any legal provisions which make available to them free care or insurance coverage--such as eligibility requirements for Medicaid or policies which enable them to obtain confidential services from a managed care plan in which their family is enrolled -- are critical in ensuring their access to care . . . .

A Quick Overview of Some Basic Resources

Confidentiality and Informed Consent: Selected References

I. General Information on Ethical Issues

School counselors and consultants: Legal duties and liabilities. Special Issue: Consultation: A paradigm for helping: II. Prevention, preparation, and key issues.
M. M. McCarthy & G. P. Sorenson (1993). *Journal of Counseling & Development*, 72, 159-167.

Ethical and Legal Issues in School Counseling.
W. C. Huey & T. P. Remley, Jr. (Eds.). Alexandria, Va. : American School Counselor Association, 1989.

The need to know: Juvenile record sharing.
J.A. Rapp, R.D. Stephens & D. Clontz (1989). Malibu, CA: National School Safety Center.

Student's rights in mental health treatment
Denver School Based Clinics (1988). Denver, CO: Denver School-Based Clinics.

State Minor Consent Statues: A Summary
A. English & M. Matthews (1995). San Francisco, CA: Center for Continuing Education in Adolescent Health.

School-based preventive interventions for at-risk populations: Practical and ethical issues.
L. K. Gensheimer, T. S. Ayers, & M. W. Roosa (1993). *Evaluation & Program Planning*, 16, 159-167.

Student's suit for confidentiality breach.
Mental & Physical Disability Law Reporter (1987), 11, 195.

Principles of biomedical ethics.
T.L. Beauchamp & J.F. Childress (1989). New York: Oxford University Press.

Professional conduct and legal concerns in mental health practice.
J. Rinas & S. Clyne-Jackson (1988). Norwalk, CT: Appleton & Lange.

Position Statement: *The School Counselor and Confidentiality* (1986). American School Counselor Association. Alexandria, VA.

Code of Ethics for Peer Helping Professionals. (1989). National Peer Helpers Association, Glendale, CA.

Ethical Standards for School Counselors. (1988). American Association for Counseling and Development. Alexandria, VA.

Code of Ethics for School Nurses. (1996). National Association of School Nurses, Inc. Scarborough, ME.

NASW Code of Ethics. (1993). National Association of Social Workers. Washington, DC.

Principles for Professional Ethics: Standards for the Provision of School Psychological Services. Professional Conduct Manual. (1992). National Association of School Psychologists. Bethesda, MD.

II. Confidentiality and Interagency Collaborations

School-based health clinics: Legal issues. (see abstract)
A. English & L. Tereszkiewicz (1988). San Francisco, CA: National Center for Youth Law.

Confidentiality and collaboration: Information sharing in interagency efforts. (see abstract)
M. Greenberg & J. Levy (1992). Denver, CO: Education Commission of the States.

Tackling the confidentiality barrier: A practical guide for integrated family services. (see abstract)
L. J. Hobbs (1991). San Diego, CA: County of San Diego, Department of Social Services.

Confidentiality: A guide to the federal laws and regulations. (see abstract)
Legal Action Center (1991). New York, NY: Legal Action Center.

Handbook: Legal issues for school-based programs. (see abstract)
Legal Action Center (1991). New York, NY: Legal Action Center.

Glass walls: Confidentiality provisions and interagency collaborations. (see abstract)
M.I. Soler; A.C. Shotton & J.R. Bell (1993). San Francisco, CA: Youth Law Center.

Reports on work in progress: Confidentiality regulations as barriers to interagency collaboration.
M. Soler & C. Shauffer (1992). San Francisco, CA: Youth Law Center.

Who should know what? Confidentiality and information sharing in service integration.
M. I. Soler & C. M. Peters (1993). New York, NY: National Center for Service Integration.

III. Students' Understanding: Confidentiality and Informed Consent

The child's conception of confidentiality in the therapeutic relationship.
C. B. Messenger & J. M. McGuire (1981). *Psychotherapy: Theory, Research & Practice*, 18, 123-130.

Children's understanding of risks and benefits of psychotherapy. N. Kaser-Boyd, H.S. Adelman, & L. Taylor (1986). *Journal of Clinical Child Psychology, 15,* 165-171.

Children's participation in consent for psychotherapy and their subsequent response to treatment. H.S. Adelman, N. Kaser-Boyd, & L. Taylor (1984). *Journal of Clinical Child Psychology, 13,* 170-178.

Perspectives of children regarding their participation in psychoeducational treatment decision making. L. Taylor, H.S. Adelman, & N. Kaser-Boyd (1983). *Professional Psychology: Research and Practice, 14,* 882-894.

IV. Brief Research Syntheses Available from the ERIC Clearinghouses

A variety of useful documents prepared by the ERIC Clearinghouses are available in libraries, over the Internet, or directly from the Educational Resources Information Center (ERIC) by phone, 1-800-LET-ERIC.

For information on searching for and accessing ERIC documents over the Internet, see the Internet Resources section of this introductory packet.

The following is a brief sampling of ERIC Digests (research syntheses) related to confidentiality and other ethical issues.

An example of a complete digest is at the end of this sample packet.
1990, ED 315 709 Ethical & Legal Issues in School Counseling. Highlights: ERIC/CAPS Digest

Abstracts of Selected Resources on Confidentiality & Interagency Collaborations

English, A.; & Tereszkiewicz, L. (1988). *School-health clinics: Legal issues.* San Francisco, CA: National Center for Youth Law.

This monograph by the Adolescent Health Care Project of the National Center for Youth Law and the Support Center for School-Based Clinics of the Center for Population Options provides an overview of school-based clinics and covers the legal framework for providing health care to adolescents, consent issues, confidentiality, and liability of school-based clinics. Appendices describe public health care funding programs; list state statutes pertaining to emancipation of minors, informed consent, and child abuse reporting, and confidentiality provisions of federal funding statutes; and summarize the confidentiality statements of leading professional organizations.

Copies of this monograph are available from:

National Center for Youth Law
114 Sansome Street, Suite 900
San Francisco, CA 94104
415/543-3307

Soler, M.I.; Shotton, A.C.; & Bell, J.R. (1993). *Glass walls: Confidentiality provisions and interagency collaborations.* San Francisco, CA: Youth Law Center.

This study contains an extensive discussion and many examples of the statutes, regulations, release forms, interagency agreements and other materials described in this brief.

The study is available from:

Youth Law Center
114 Sansome Street, Suite 950
San Francisco, CA 94104
415/543-3379

Oregon Departments of Education, Corrections, and Human Resources. (1991). *A study of confidentiality as a barrier to service delivery.* Salem, Oregon: Oregon Departments of Education.

Copies may be requested from:

Barbara Ross
Department of Human Resources
Director's Office
320 Public Service Building
Salem, Oregon 97310

Greenberg, M.; & Levy, J. (1992). *Confidentiality and collaboration: Information sharing in interagency efforts.* Denver, CO: Education Commission of the States.

This report by the Center for Law and Social Policy, Joining Forces, American Public Welfare Association, Council of Chief State School Officers, and the Education Commission of the States discusses confidentiality in interagency collaborations, provides examples from a variety of disciplines, and offers guidelines for developing an approach to information-sharing, handling "informed consent", using aggregate data and automated data systems, protecting confidentiality, and working with legislatures. Appendices contain sample release forms, a checklist for staff responsible for obtaining consent, staff oaths, a list of key federal statutes, and additional resources.

This report can be obtained from:

Education Commission of the States (ECS)
Distribution Center
717 17th Street, Suite 2700
Denver, CO 80202-3427
303/299-3692

Hobbs, L.J. (1991) ***Tackling the confidentiality barrier: A practical guide for integrated family services.*** **San Diego, CA: Department of Social Services.**

This report prepared for San Diego's collaborative New Beginnings initiative reviews federal, California and local San Diego statutory and regulatory requirements for managing confidential information across publicly funded health, education and social service programs. The report analyzes the issue, suggests management strategies to minimize problems, offers model procedures and forms and recommends changes in law and administrative policy to facilitate responsible exchange of information. Appendices contain compilations of relevant federal, state and local statutes and regulations.

Copies of the report and appendices are available from:

Department of Social Services
County of San Diego
Community Relations Bureau, Room 843
1255 Imperial Avenue
San Diego, CA 92101-7439
619/338-2860

National Association of Social Workers, Commission on Education. (1991). ***Position statement: The school social worker and confidentiality.*** **Silver Spring, Maryland: National Association of Social Workers.**

This position statement describes general ethical and legal issues facing school social workers, with particular attention to situations that frequently arise in the school setting. The document includes references and an annotated bibliography.

Copies are available from:

National Association of Social Workers
750 First Street N.E.
Washington, D.C. 20002

Legal Action Center. (1991) ***Handbook: Legal issues for school based programs.*** **New York, NY: Legal Action Center.**

This handbook is written for agencies providing alcohol and drug treatment and prevention services for students. It includes a discussion of federal alcohol and drug abuse regulations, issues in structuring a student assistance program, and issues with respect to the relationship between a student's right of confidentiality and a parent's right to information under the Federal Educational Rights and Privacy Act (FERPA).

Legal Action Center. (1991) ***Confidentiality: A guide to the federal laws and regulations.*** **New York, NY: Legal Action Center.**

This manual offers a detailed review of federal statutes and regulations pertaining to alcohol and drug abuse prevention and treatment programs, and a discussion of common confidentiality problems that arise in such programs. Appendices contain form releases, notices, letters in response to subpoenas, and interagency agreements.

Copies of these reports may be purchased from:

Legal Action Center
153 Waverly Place
New York, NY 10014
212/243-1313

National Academy of Sciences, Committee on National Statistics, Panel on Confidentiality and Data Access

The Committee on National Statistics and the Social Science Research Council have jointly convened a panel to study issues of confidentiality and data access and to provide recommendations to federal agencies for better accommodating the increasing tension between data access and confidentiality. This study focuses almost entirely on statistical agencies and on statistical and research uses of data. Many of the issues being considered by the Panel may have general applicability to state, local and nongovernment agencies establishing policies regarding the handling of confidential materials.

This committee can be contacted at:

Committee on National Statistics
National Academy of Sciences
2101 Constitution Avenue N.W.
Washington, D.C. 20418
202/334-3096

Mental Health Law Project; National Early Childhood Technical Assistance System; and Division for Early Childhood of The Council for Exceptional Children. ***Strengthening the role of families in states' early intervention systems: Policy guide to procedural safeguards for infants and toddlers and their families under Part H of the Education of the Handicapped Act.*** **Washington, D.C., 1990.**

This document describes the law and presents a set of proposed policies for addressing issues of consent, notice of rights, rights to review and correct records, confidentiality and procedures for resolving parental complaints in the implementation of systems of early intervention services for infants and toddlers under Part H of the Education of the Handicapped Act. Many of the procedural safeguards identified may have general applicability to other programs serving children and families.

Copies may be purchased from:

Division for Early Childhood/Council for Exceptional Children
Publication Sales
1920 Association Drive
Reston, Virginia 22091-1589

Some Models for Dealing with Confidentiality and Informed Consent

In this section, we have abstracted information from five different sources that provide models of how to handle Confidentiality and Informed Consent. Each source describes how it approaches these concerns and provide sample forms.

1. **From document entitled *Glass walls: Confidentiality provisions and interagency collaborations* (1993). San Francisco, CA: Youth Law Center. Prepared by M. I. Soler, A. C. Shotton & J. R. Bell.**

A. The interests of children and families in protecting private information from unauthorized disclosure are significant and should not be disregarded. These interests include:

1. The core interest in privacy ("the right to be let alone");
2. Avoiding embarrassment and humiliation from disclosure of personal or family problems;
3. Avoiding exposure of information that is inherently inflammatory (such as allegations of child abuse or mental instability), even if the information is unproven or inaccurate;
4. Protecting personal security (such as the location of victims of domestic violence);
5. Protecting family security (such as citizenship status, for immigrant families);
6. Protecting job security, particularly when personal problems may have no connection with actual job performance;
7. Avoiding prejudice or stereotyped responses as a result of information on family income level, medical status, or past difficulties;
8. Preventing denial of discretionary services;
9. Encouraging adolescents to seek medical care; and
10. Reestablishing privacy boundaries for children, especially after abuse or multiple out-of-home placements.

B. Balanced with these interests in privacy are the interests of agencies in sharing information. In many situations, children and families share these interests in the effective and efficient provision of services. The interests of agencies (and families) include:

1. Conducting comprehensive child and family assessments and evaluations for services;
2. Providing children and families with all necessary services;
3. Coordinating service plans and strategies and avoiding duplication of services;
4. Monitoring the provision of services;
5. Making services family-focused;
6. Allowing research on community needs and program effectiveness;
7. Promoting public safety (e.g. by sharing information about potential child care workers regarding prior criminal convictions); and
8. Securing full reimbursement form federal and other funding sources for services provided.

C. Reviews of privacy protections and confidentiality restrictions in federal and state constitutions, statutes, regulations, and agency practices, as well as those in various professional standards indicate that confidentiality restrictions are not significant barriers to interagency collaborations. Further, confidentiality restrictions are not absolute, but instead balance individual interests in privacy against agency interests in providing effective services.

D. Some information, such as that which does not identify specific individuals, is not confidential at all and may be shared freely. Other very basic information, like educational "directory information," is also not considered confidential.

E. The most common way of information-sharing takes place through informal exchanges, usually verbal and by telephone. This generally occurs between workers in different agencies who have developed a high degree of trust and cooperation. However, if documents need to be shared, a written release or other formal mechanism is required. (see Sample Form A.)

F. Most statutes explicitly authorize a certain degree of information-sharing without consent of the individual for purposes such as:

1. Administration of the program;
2. Audits;
3. Determinations of eligibility for services;
4. Medical emergencies;
5. Investigations, prosecutions, or civil or criminal proceedings related to program administration.

G. Virtually, all statutes authorize information-sharing with the consent of the client. Such information-sharing generally requires a written release specifying the following:

1. Name of the person who is the subject of the information;
2. Name of the person or agency with whom the information will be shared;
3. The reasons for sharing the information;
4. The kind of information that will be shared;
5. The signature of the person giving consent;
6. The date the release is signed;
7. A statement that the release may be revoked at any time by the person giving consent;
8. An expiration date for the release; and
9. A statement that the person giving consent is entitled to a copy of the release. (see Sample Forms B, C, D & E.)

H. Agencies may enter into agreements such as interagency agreements, memoranda of understanding, contracts, court orders, and other mechanisms for sharing information among agencies. (see Sample Forms F & G). A good example of using these mechanisms simultaneously is the Caring Connection program in Iowa (see Sample Form H) and the Fulton County Kids Project in Kentucky. (see Sample Form I.)

I. In using aggregate information systems, particularly automated information systems containing identifiable information, protective mechanisms must be in place to ensure the proper disclosure of confidential information. Using such systems while ensuring client privacy requires the following:

1. Clarifying the purposes of the information system;
2. Limiting the information in the system to that truly needed to fulfill those purposes;
3. Securing the cooperation of multiple agencies in developing and operating the system;
4. Providing adequate notice to children and families that information about them is being put into an information system and will be accessible to others for specific purposes;
5. Maintaining several levels of security in the system;
6. Providing adequate training for staff.

J. It is the responsibility of agency workers to comply with whatever established procedures for information sharing and confidentiality. This may include such methods as staff training and training materials, staff oaths and other restrictions and the roles of agency counsel and other "gatekeepers".

BEST COPY AVAILABLE

Sample Form A

SAN DIEGO D-R-A-F-T RELEASE - LIMITED

EXAMPLE OF LIMITED AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

CONSENT TO PARTICIPATE AND AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I. PROGRAM PURPOSE: (Statement must answers who, what and why)

The Center is a service jointly funded and governed by city, county, private and school agencies for families and children served by the school. The names of participating agencies and programs are: (Specify the names of the agencies/programs must be stated to assure the participant is properly informed.) All have agreed to cooperate to better serve you and your child(ren) and to protect your confidential records. The purpose of the Center is to provide families the support they need to enable their child(ren) to achieve maximum academic, social and personal growth; and to assist families in obtaining health, education, social and community services as needed.

II. REASON FOR LIMITED RELEASE: (Statement must give the purpose of the release)

Center staff and staff from the participating agencies (hereafter called Extended Team) who work at or with the Center need to communicate with each other on your behalf. Your initials and signature on this form gives your written consent for Center staff and the Extended Team to verbally share certain information on your family circumstances. This release also gives designated Center staff permission to review and record certain information from the automated files of the participating agencies. The purpose is to: better coordinate services between the Center and participating agencies who can or are providing services to you, your child(ren), or your family; minimize duplicate efforts by you and the staff working on your behalf to verify certain facts about the family held by a participating agency; and develop the best service plan for and with you.

III. PARTICIPANT AGREEMENT/AUTHORIZATION: Initial the black line(s) to acknowledge you have read, understand, and agree with the statements.

___. I wish to receive services from the Center for my child(ren) enrolled in the school, myself, and other members of my family for whom I am the parent or guardian.

___. I authorize Center case management staff and Extended Team members from the participating agencies to verbally exchange the following personal information only about me and my minor child(ren) from their case files: (Identify the information to be exchanged.)

Example statement: Summary information about the agency(s) service plan for health, education and social services, and the level of achievement of the plan(s). Summary is defined as general statements only and precludes diagnosis and specific treatment information on any services given by a health care provider and any information specifically precluded by law under this simplified procedure.

Sample Form B

County of San Bernardino
CHILDREN'S INTERAGENCY

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

PLEASE TYPE/PRINT ALL INFORMATION

Child's Name _____ Birth Date _____

Mother's Maiden Name _____ Father's Name _____

Social Security No. _____ Record No. _____

I authorize San Bernardino County Department of _____
to exchange information with:

_____
Agency/Person/Organization

_____
Address

about information obtained during the course of my/my child's treatment/case/service plan for

_____.

The exchange of records authorized herein is required for the following purpose:

_____.

Restriction: Release or transfer of the specified information to any person or agency not named herein is prohibited unless indicated below:

Such exchange shall be limited to the following specific types of information: _____

_____

_____.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate, without express revocation on:

_____.
Date, Event, or Condition

I understand I am entitled to receive a copy of this consent. _____ copy(ies) requested and received.
I have read this consent carefully and have had all my questions answered.

Date _____ Witness _____

Signed _____ Signed _____
Parent, Guardian, Conservator *Case Manager/County Representative*

BEST COPY AVAILABLE 27 Agency _____

– CONFIDENTIAL CLIENT INFORMATION –

SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND SECTION 10850. CIVIL CODE 34, 56 and 1798. 42 C.F.R. SECTION 2.34 AND 2.35. EDUCATION CODE 49075. HEALTH AND SAFETY CODE 1795.

RELEASED RECORDS

The following records and/or information was released to:

_____

- ☐ Summary of Record
- ☐ Diagnosis/ Assessment
- ☐ Social History
- ☐ Treatment Plan
- ☐ Financial Information
- ☐ Psychiatric Evaluation
- ☐ Medical Assessments, Lab Tests, etc.
- ☐ History of Drug/ Alcohol Abuse
- ☐ Other Evaluations/ Assessments *(specify)*

_____
_____
_____
_____

- ☐ Results of Psychological/ Vocational Testing
- ☐ Other *(specify)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Released by:

SIGNATURE _____

TITLE _____ DATE ___/___/___
Month Day Year

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Citation Examples:

Health and Safety Code 5
W&I Code 10850 and 5328
Ed. Code 49075
Civil Code 56 and 1796
42 CFR Part 2

Case Name:

Case Record No.:

Date of Birth:

BEST COPY AVAILABLE

Sample Form C

LINN COUNTY, OREGON

ALBANY YOUTH SERVICES TEAM
AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____, authorize the release of information between and among
Parent/Guardian Signature

the identified Albany Youth Services Team members which will be planning services for

_____.
Client(s) Name(s) (Please include all family members)

The purpose of the Authorization Form is to enable agencies identified as members of the Alban Youth Services Team to better serve your child through coordinated service planning and delivery Representatives of these agencies will meet and share information regarding your child a scheduled planning and review meetings.

The Albany Youth Services Team for your child shall include the following agencies:

- Greater Albany Public Schools
- Children's Services Division, Linn and Benton Counties
- Linn and Benton County Alcohol & Drug Treatment Programs
- Linn County Dept. of Health Services
- Linn-Benton Education Service District
- Adult and Family Services
- Linn and Benton County Juvenile Department
- Albany Police Department
- Linn and Benton County Sheriff's Department
- Oregon State Police
- State of Oregon Parole and Probation
- Other_____

To assist in determining the availability of resources, please put a check in the box if your ch has a:

☐ Medical Card or ☐ Private Insurance

The information which may be disclosed/exchanged is: presence in the program, and school, le and treatment records which include assessment, family history, diagnoses and treatme recommendations from the Linn County Mental Health and Alcohol and Drug Treatment Progran

This release authorizes a free exchange of information between members in order to give the mc complete and thorough services available. It does not authorize release to any other person agency except those agencies listed above. Unless revoked in writing, this release and exchan shall remain in force for a period of 12 months from the date of authorization.

To the party receiving this information: This information has been disclosed to you from reco whose confidentiality is protected by federal law. Federal regulation (42 CDR Part 2) prohit you from making any further disclosure of it without the specific written consent of the pers to whom it pertains, or as otherwise permitted by such regulations. A general authorization the release of medical or other information is not sufficient for this purpose.

_____ _____
Witness Authorizing Signature

_____ _____
Date Relationship to Child

_____
Juvenile's Signature (12 and over)

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Revised 1

LONGFELLOW ELEMENTARY SCHOOL
3610 Eucalyptus Avenue
Riverside, California 92507

Sample Form D
(English Version)

Interagency Project SMART Program
Authorization to Release Information

We have many services here at Longfellow to help you and your family. To receive this help and to make sure that you get all the help you and your family needs we may need to share information. I, _____, hereby authorize release of all records, documents and information on my son, my daughter, and/or my family which is or may come on file with the agencies here at Longfellow Elementary School/Project SMART.

The following agencies may or will provide the services:

- The Youth Service Center
- Mental Health Counselor
- Public Health Nurses
- Public Health Van
- Social Worker
- Psychologist
- State Evaluator
- GAIN Worker
- AFDC Eligibility Technician
- MediCal Technician
- Day Care
- The Family Advocate
- School personnel

I understand that the following information may be released to the above stated providers:

1. The full name and other identifying information regarding my child and our family.
2. Recommendations to other providers for further assistance.
3. Diagnostic and assessment information including psychological and psychiatric evaluations, medical histories, educational and social histories. These evaluations may include some or all family members.

The purpose of this disclosure shall be to facilitate service delivery to my child(ren) and my family. I further understand that the information generated or obtained by the project can be shared with the agencies or providers that are a part of this project.

I also understand that this Authorization for Release of Information will be in effect for the duration of services provided to my child(ren) and my family and will expire upon the termination of the services. I understand I can revoke this consent at any time and this consent shall be reviewed annually.

I certify that I have read and understood the consent of this form. _____ Yes, I agree to sign.
_____ No, I do not agree to consent. **Please list all children attending Longfellow School.**

_____ Parent or Guardian Name (Please Print)

_____ Parent or Guardian Signature

_____ Student's Name _____ Room #

_____ Authorized Project SMART Staff

_____ Student's Name _____ Room #

_____ Date

_____ Student's Name _____ Room #

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LONGFELLOW ELEMENTARY SCHOOL
3610 EUCALYPTUS AVENUE
RIVERSIDE, CALIFORNIA 92507

Sample Form D
(Spanish Version)

Programa del Proyecto SMART de Interagencias
Autorizacion Para dar Informacion

Tenemos muchos servicios aqui en la escuela Longfellow para ayudarle a usted y a su familia. Para recibir esta ayuda y para asegurarnos de que reciba usted y su familia la ayuda necesaria, tal vez sea necesario compartir información. Yo, _____ doy autorización de compartir toda información del expediente, documentos, e información sobre mi hijo, mi hija, y/o mi familia que pueden estar en el archivo en las agencias aqui en la Escuela Longfellow y el Proyecto SMART.

Las siguientes agencias pueden o serán las agencias que darán los servicios:

- Centro de Servicio Juvenil
- La consejera de salud mental
- Las enfermeras de salud publica
- Camión de Salubridad
- La trabajadora social
- El Psicologo
- El evaluador del estado
- Trabajador de Gain
- Trabajadores de Eligibilidad de AFDC
- Trabajador de MediCal
- Cuidado de niños
- La Ayudante de Familias
- Personal de la escuela

Yo entiendo que la siguiente información puede ser compartida con las personas mencionadas arriba:

1. El nombre completo y otra información de identificación sobre el niño o la famila.
2. Recomendaciones a otras agencias para recibir más ayuda.
3. Información sobre examenes de Diagnóstico y evaluación del psicologo o psiquiatra, historia medica, y antecedente educativo y social. Esta información puede ser sobre toda o parte de la familia.

La razón por la cual se necesita toda esta información es para facilitar servicio a todos mis niños o la familia. Yo entiendo que esta información será unicamente usada para este proyecto y solo sera dada a las agencias que son parte de este proyecto.

Yo entiendo que esta Autorización de Información sera vigente durante el servicio dado a mis hijos y familia y expira al terminar los servicios. Yo entiendo que yo puedo revocar este consentimiento en cualquier momento y que yo revisaré este consentimiento cada año.

Yo certifico que yo he leído y entiendo este documento. _____ Si, Yo estoy de acuerdo firmar. _____ No, Yo no estoy de acuerdo firmar. Por favor ponga todos los nombres de sus ninos que asisten a la escuela Longfellow.

_____
Nombre del Padre o Tutor(Letra de molde)

_____
Firma del Padre o Tutor

_____ _____
Nombre del estudiante(s) Salon

_____
Firma de Persona de Proyecto SMART

_____ _____
Salon

_____ _____
Salon

_____
Fecha

_____ _____

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Sample Form E

CONSENT TO TREATMENT
AND
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION:
BLUEGRASS INTERAGENCY MOBILIZATION
FOR PROGRESS IN ADOLESCENT AND CHILDREN'S TREATMENT
INTERAGENCY INFORMATION EXCHANGE

I, _____, hereby declare that I am the parent _____ or guardian _____ of _____, who is a child (SS# __ __ __ - __ __ - __ __ __ __) applying for services provided by Bluegrass IMPACT, a project of the Cabinet for Human Resources and the Bluegrass Regional Mental Health/Mental Retardation Board, Inc. I hereby give permission to those agencies or providers affiliated with Bluegrass IMPACT, a listing of which has been given to me, to provide services to my child including consultation with agencies which may not have had direct contact with my child.

I recognize that the services for my child's condition require the collaboration of numberous agencies and service providers. I understand that this collaboration requires the disclosure of information about my child so as to help the various service providers to make necessary assessments and service plans.

I understand that the following information may be released to service providers:

1. The full name and other identifying information regarding my child and our family.
2. Diagnostic and assessment information including psychological and psychiatric evaluations, medical histories, educational and social histories. These evaluations may include references to other family members.
3. Treatment and/or educational rehabilitation or habilitation plans.
4. Current observations of behavior.
5. Recommendations to other providers.

The purpose of this disclosure shall be to facilitate service delivery to my child.

I further understand that the information generated or obtained by the project can be shared with the agencies or providers affiliated with the project.

This authorization to release information extends to the various interagency committees and response teams of project IMPACT. I authorize data to be shared with the Cabinet for Human Resources, Department for Mental Health and Mental Retardation Services, Division of Mental Health. The purpose of this disclosure is to assist in needs assessment and planning for future services.

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MEMORANDUM OF UNDERSTANDIN
BETWEEN THE NEW YORK STATE DEPARTMENT ? HEALTH AND THE NEW YORK STATE DIVISION OF ALCOHOLISM AND ALCOHOL ABUSE

WHEREAS, the Division of Alcoholism and Alcohol Abuse (DAAA) has a statutory responsibility to establish and operate alcoholism treatment and rehabilitation services; and

WHEREAS, both the Department of Health (DOH) and DAAA have promulgat HIV confidentiality regulations pursuant to Article 27-F of the Publ Health Law allowing for the disclosure of information to state agencies when necessary for the supervision, monitoring or administration of a program; and

WHEREAS, DAAA funds Alcoholism/HIV Coordinators through Community Service Programs (CSPs) whose activities must be monitored and evaluated by DAAA through data collection, and DOH funds CSPs whose activities must be monitored and evaluated through data collection; and

WHEREAS, DOH has developed and implemented an existing information system to monitor and evaluate the CSP as a whole; and

WHEREAS, both DOH and DAAA are committed to reducing duplication of effort in data collection and reporting by the CSP;

NOW, therefore, DOH and DAAA do hereby agree as follows:

1. DOH and DAAA will jointly adhere to established procedure for the collection and sharing of data necessary to monit Alcoholism/HIV Coordinator activities.

2. DOH will add codes specific to alcoholism services to the forms used by CSPs for reporting client services rendered and will note that information will be utilized by DOH an DAAA. Such codes will not contain client identifying information.

3. In order to comply with federal and state confidentiality laws, DAAA and DOH will strictly maintain the confidentiality and security of shared data through the following procedures:

   a. Data transactions between DAAA and DOH will occur primarily via computer disk. Use of this and other media for transmission shall adhere to specified regulations and other procedures set forth in this agreement.

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b. DAAA will submit to DOH a list of non-ide fying alcoholism client numbers for individuals .. whom data is required. Such requests will be limited to one per calendar quarter.

c. DOH will return alcoholism client number list with the requested data.

d. DAAA will restrict access to client data from CSP providers and Alcoholism/HIV Coordinators permitting access only to DAAA staff who have been authorized by DAAA to enter, edit and analyze said data.

e. DAAA shall develop and will adopt guidelines concerning the reporting of statistical data to be implemented i instances where low frequencies in tabular cells may jeopardize confidentiality.

4. DAAA agrees to submit budget requests including funds to support initiatives contained in the AIDS Five Year Plan for which DAAA has implementation responsibility during the corresponding fiscal year, unless funding from an alternat source is known to be available to support such implementation.

5. This agreement will commence April 1, 1990 and remain in effect until termination by either party. To terminate, a party must give to the other part not less than sixty (60) days written notice that on and after a date therein specified, this agreement shall be terminated and cancelled

Division of Alcoholism and Alcohol Abuse

BY: Marguerite T. Saunders

NAME: Marguerite Saunders

TITLE: Director

DATE: 7/23/91

Department of Health

BY: Linda A. Randolph

NAME: Linda A. Randolph, MD, M

TITLE Director, Office of Publ Health

DATE: 8/13/91

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Sample Form G

SAN BERNARDINO COUNTY
CHILDREN'S INTERAGENCY

Protocol On Consent
To Exchange Confidential Information

Member agencies enter into this protocol to utilize one standard Release of Information form for authorization to release confidentia information and records about children and families served by one or more member agencies. This form is intended to allow the case worke to use one form to access and send records to and from other health mental health, drug and alcohol, education, probation and social services providers. The goal is to have a form which, when properly completed, allows the receiving organization to copy or file it and act upon it without further releases.

Use of a standard release form by all member agencies is intended to better coordinate services between participating agencies who can or are providing services to the same families: minimize duplicate efforts to verify certain facts needed for rendering services; and t help develop the best level of integrated, effective services.

All member agencies agree to develop written guidelines for their staff in using and accepting this form and to train their staff prio to the agreed upon date of implementation. All staff will be informed that the form must be completed in its entirety. The release shall be specific about the nature of information requested. The form shall be time limited with a specific ending date. The release must be signed and dated with a copy given to the signatory. The signatory must be fully informed of the purpose for the release. Staff shall be trained on specific exceptions in exchange of confidential information such as:

- Information given pursuant to mandatory reporting laws.
- Information from an informant, particularly a minor.
- Sensitive health information, such as HIV test results.
- Third party confidential reports, particularly medical reports.

Use of this form is to assist families to participate in the decisio to exchange information in order to receive better services. The overall intent however, is to provide families and children their full protection for confidentiality under the law and to ensure families understand and exercise their rights to privacy accordingly

Nothing in this protocol limits existing practices for exchanging confidential information at the Regional Case Management Councils established under the Children's Services Team as Multi-Disciplinary Teams authorized to exchange information under a standing court orde from the presiding juvenile court judge pursuant to WIC Section 827 and 828.

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Sample Form H

CARING CONNECTION
AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Student: _____
Birthdate: _____
Social Security Number: ____ - ____ - ____

The Caring Connection is a program designed to provide a comprehensive set of services to youth in an effort to assist teenagers in completing high school, becoming employable and remaining mentally and physically healthy.

The services available under this program are related to employment, preventative and primary health care, mental health, substance abuse and family counseling.

AUTHORIZATION

_____ desires to participate in this program and authorizes the Mental Health Center of Mid-Iowa, Inc., Substance Abuse Treatment Unit of Central Iowa, Job Training and Partnership personnel, Marshall County Youth Runaway & Family Services, Mid-Iowa Community Action, Y.M.C.A. Outreach Program, his or her school guidance counselor, school nurse, employees of the Caring Connection and _____, to exchange among
(specify any other health care providers)
themselves for coordination of services the following records relating to the student's care and treatment:

_____ summaries and notes of participation in treatment
_____ evaluations and recommendations
_____ psychological and psychiatric testing and evaluation results
_____ discharge reports
_____ academic records
_____ information relating to medical history
_____ information relating to social history
_____ information relating to alcohol and other drug use
_____ information on legal history
_____ other information

_____ understands he/she has a right to inspect the disclosed information and information being exchanged at any time, and hereby states that this authorization shall be effective for ___months from the date it is signed. _____ also understands that he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Caring Connection or the individual health care providers.

A photocopy or exact reproduction of this authorization shall have the same force and effect as the original.

I hereby authorize release of information as indicated above and acknowledge that I have received a copy of this document.

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_____ _____
Signature of Student Date

_____ _____
Parent or Legal Representative Date

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State Law applicable to substance abuse and mental health. I SPECIFICALLY AUTHORIZE release of all confidential information as set forth herein relating to substance abuse (drug or alcohol information) from the Substance Abuse Treatment Unit of Central Iowa and Mental Health Center of Mid-Iowa, Inc., and specifically authorize the disclosure of this confidential information.

_____ _____

Signature of Student Date

_____ _____

Parent or Legal Representative Date

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Sample Form I

FULTON COUNTY KIDS PROJECT
(KENTUCKY INTEGRATED DELIVERY SYSTEM)

Student Identification:

Name:_____DOB:_____
Address:_____S.S.#:_____
Parent:_____Phone:_____
Address (if different from student):_____

Permission for Service:

Permission is hereby given to the staff of the agencies participating in the Fulton County KIDS Project, as listed below, to render services to:_____
whose relationship to me is:_____Child _____Other:_____

Release of Information:

I, as parent/guardian of the above named child, hereby consent to the release of information by the participating agencies within the Fulton County KIDS Project for oral presentation only at case conference meetings. This information will not be released to other non-participating agencies/persons without the express written consent of the parent/guardian and prior written notification of the school district. I understand and have had explained to me that the sharing of information will enable the participating agencies to provide my child/family with the most efficient and effective services. This release may be withdrawn upon receipt by the school district of the written notification of revocation.

This consent form is valid for a period of time beginning _____and ending_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

I understand that the following agencies will be participating as needed in the case conference and will be exchanging oral information concerning my child/family:

Department of Vocational Rehabilitation
Department for Social Services
Department for Social Insurance
Purchase District Health Department
Commission for Handicapped Children
Department for Employment Services
Administrative Office of the Court-Juvenile Services Division
Western Kentucky Regional Mental Health-Mental Retardation Board, Inc.
Fulton County School District
Fulton Independent School District

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II. **From document entitled *The need to know: Juvenile record sharing* (1989). Malibu, CA: National School Safety Center. Prepared by J. A. Rapp, R. D. Stephens, & D. Clontz.**

A. The following records are confidential and shall not be released to the public except as permitted by this statute.

1. Juvenile court records, which include both legal and social records;
2. Juvenile social service agency, child protective service agency, or multidisciplinary team records whether contained in court files or in agency files, which includes all records made by any public or private agency or institution that has or has had the child under its care, custody or supervision;
3. Juvenile probation agency records whether contained in court files or in probation agency files.
4. Juvenile parole agency records whether contained in court files or in parole agency files;
5. Juvenile prosecutor, state's attorney, district attorney or county attorney records relating to juvenile cases;
6. Juvenile law enforcement agency records, including fingerprints and photographs; and
7. School records maintained by school employees on all students, including, but not limited to, academic, attendance, behavior and discipline records.

B. Access to the records listed in Section A is permitted without court order for official use to the following:

1. All courts;
2. All probation or parole agencies;
3. All attorneys general, prosecutors, state's attorneys, district attorneys and county attorneys;
4. All social service or protective service agencies or multidisciplinary teams;
5. All law enforcement agencies;
6. All schools attended by the minor; and
7. All persons, agencies or institutions that have responsibility for the custody, care, control or treatment of the minor.

C. The juvenile court may issue an order releasing juvenile records to any person, agency or institution asserting a legitimate interest in the case or in the proceedings of the juvenile system.

D. Juvenile records may be sent to a central repository, which may be computerized. The central repository may be accessed by all agencies and organizations listed in section B above.

E. The juvenile, the juvenile's parents or guardian, and the juvenile's attorney may have access to the legal records maintained on the juvenile in possession or the juvenile court without court order. The juvenile's attorney may have access to the social records maintained on the juvenile in possession of the juvenile court and to the records listed in Section A of this statute for use in representation of the juvenile. The juvenile about whom records are maintained may petition the court to correct any information that is incorrect.

Note: Other Disclosures of Juvenile Records

Several states in recent years have modified their juvenile records statutes to allow public disclosure of records involving serious crimes. Typically, such statutes allow the public to have access to records regarding felony crimes committed by minors who have reached age 15 or 16. Many states also allow victims to obtain information about juvenile records in order to pursue civil remedies.

Such clauses are extremely important and should strongly be considered by those re-drafting their state juvenile records statutes. However, those clauses were purposely left out of this Model Statute because the model focuses only on child-serving agencies sharing records with each other in order to make better professional decisions about children -- not on the wider issue of records access by the general public.

III. **From document entitled *Confidentiality and collaboration: Information sharing in interagency efforts* (1992). Denver, CO: Education Commission of the States (ECS). Prepared by Joining Forces, American Public Welfare Association, Center for Law and Social Policy, Council of Chief State School Officers and Education Commission of the States.**

Here is a sample form provided in this work. Other sample forms are included in this resource.

Sample Form
Authorization to Release Information

COUNTY OF CONTRA COSTA
INTERAGENCY FAMILY PRESERVATION PROGRAM
Authorization to Release Information

I, _____, hereby authorize release of all records, documents, and information on my son, daughter, and myself and/or my family which is or may come on file with Contra Costa County Mental Health Department, Social Service Department, Probation Department, local school agency and Families First to and between these agencies for their utilization when meeting and planning services through their Interagency Referral Committee. I may revoke this consent at any time by notifying the Interagency Referral Committee in writing of my desire to withdraw the consent given herein.

_____ _____
Signature of Consenter Date

_____ _____
Witness Date

_____
Agency and Title of Witness

IV. **From document entitled *First steps: A guide to integrating information for systems evaluation of children's mental health services* (1996). Boston, MA: Judge Baker Children's Center, The Technical Assistance Center for the Evaluation of Children's Mental Health Systems. Prepared by D. Hallfors, P. McQuide, C. Brach, & S. Hutcheson.**

Any discussion of sharing information across agencies and with the public, particularly in a computerized format, raises issues of confidentiality, access to information, and privacy rights. Children and families who are being served by public agencies are required to reveal a great deal of intimate and private information about themselves. Much of this information is essential for agencies to make decisions about eligibility and to determine appropriate services, while some of it may be relevant to the overall family situation but not essential to the agency's specific mission. Especially as agencies begin deliberations about sharing information across agencies, they must be alert to the potentially serious consequences of failing to protect the privacy of children and families.

Children and families have a clear interest in privacy protection. This interest might stem from their need to avoid stigmatization from disclosure of personal or family issues; to protect personal security (such as the location of victims of domestic violence); to protect family security (such as citizenship status, for immigrant families); to protect job security; to avoid prejudice or stereotyped responses as a result of information on family income level, medical status, or past difficulties; to prevent denial of discretionary services; and to reestablish privacy boundaries for children, especially after abuse or multiple out-of-home placements.

The interests of children and families in personal privacy are of undeniable importance. When children and families need public services, however, the individual's right to privacy is met by the agency's need to share information for effective and efficient provision of services. Counterbalancing children and families' need for confidentiality are agencies' need to:

- conduct comprehensive child and family assessments and evaluations for services;
- provide children and families with all necessary services;
- coordinate service plans and strategies, and avoid duplication of services;
- monitor the provision of services;
- insure services are family-focused;
- allow research on community needs and program effectiveness;
- promote public safety (e.g., by sharing information about potential child care workers regarding prior criminal convictions); and
- secure full reimbursement from federal and other funding sources for services provided.

With the coming of automated information systems, agencies are encouraged to collect more information, because the computer gives them the capacity to manage large data sets more easily. However, especially when agencies are considering ways of sharing information they will find that having more information is not necessarily better. Collecting unnecessary information may:

- increase the danger of inappropriate disclosure of information,
- increase costs for collecting and managing information,
- make information sharing more cumbersome, and
- increase the probability that erroneous or misleading information will be disseminated.

Solutions to privacy concerns cannot be legislated or mandated. Open exchange of ideas and the building of trusting relationships will be a first step to addressing privacy concerns. All the relevant parties including family representatives need to be involved in the planning and decision making. They need to see themselves as working toward a common goal which is well served by having agencies share information.

Many administrators regard confidentiality statutes and related regulatory provisions as major impediments to interagency efforts. The 1991 study by the Youth Law Center of San Francisco, which assessed confidentiality issues in interagency collaboration, provides a comprehensive discussion of issues to consider, along with useful mechanisms for sharing information (Soler, Shotton, and Bell 1993). An analysis of legal and ethical issues related to confidentiality reveals that virtually all information-sharing problems can be resolved. Most of the administrators interviewed in the Youth Law Center study indicated that they believed that confidentiality issues are frequently exaggerated and often cover up underlying interagency conflicts over ownership of the data and budget control. However, certain safeguards are necessary in developing computerized information systems, primarily when the systems contain identifiable information on individuals.

Listed below are strategies that agencies can use to overcome conflicts on confidentiality issues after consensus has been built in the planning/decision making process.

Notify children and families of data sharing arrangements and use mechanisms such as written releases signed by families to authorize the sharing of sensitive data. Families should be notified that certain information is being put into an automated data system and that it will be accessible to others for specific purposes. The notice should specify the type of information put into the system, the particular individuals or agencies who will have access to it, the reasons for which they may have access to the information, and how they will use it. If the information-sharing requires the consent of the client, agencies should consider the following advice on developing a release form from the Task Force on Enhancing the Mental Health Statistics Improvement Project (MHSIP) to Meet the Needs of Children:

- Avoid broad or blanket releases.
- Print releases in multiple languages.
- Clearly identify the collaborating agencies.
- Specify who is covered by the release and the type and scope of information to be released.
- Explain how the information will be used, by whom, and for what purpose and the benefits and risks associated with releasing, as well as the potential benefits and risks associated with not releasing the information.
- Include the termination date of the release, which includes the mechanism to terminate the release before the date.

Clarify the purposes of the system. It is important to keep the purposes of the automated system clear to provide a solid basis for determining what data elements must be included in order to attain the desired goals. Losing sight of the goals can easily lead to the inclusion of data that might be useful someday but does not have any immediate application.

Employ the Principle of Limited Information. Limit information going into the system to that which is truly needed to fulfill its purposes. For example, if the database will include the information that a person received medical treatment, it may be sufficient just to indicate when and where, and not to include the details of the client's medical condition and the specifics of the treatment.

Use non-identifiable information when identifiable information is not needed to accomplish goals. Aggregate data or individual data that masks the identity of individuals whose information is in the system may be used for many of the planning and evaluation functions of integrated information systems. A number of masking identifiers may be used, including identifying numbers assigned by agencies. Some systems have specialized methods of developing identifiers, such as using certain letters from the last name. The uniqueness of the identifier is critical to maintaining confidentiality. In a cross-agency information system, if identifiers are not unique (e.g., a last name of "Jones"), an agency worker may need to browse through records of a number of persons named Jones to find a particular client. If the worker is relying on a written release from the client to obtain the information, such a lack of precision will result in breaches of confidentiality as the worker views confidential information on other individuals while looking for a specific client.

Establish appropriate security. Automated data systems need several levels of security, beginning with security of the physical environment. Physical access to confidential information on disks, tapes, and at workstations should be controlled.

The second level of security is limiting access to the data once they are in the computer system. This can be done with a series of passwords, with each successive password allowing the user to get deeper into the system. A more flexible alternative is to have the system administrator create security profiles which define the package of screens each user can view and limit the functions the user can perform. The security profile would be constructed to give each user (agency worker, researcher, etc.) access only to the information that the user has a legitimate need to know or use. The security profile would use a single password to gain entry, and the system could be programmed to automatically time out people who cannot get their passwords correct after several attempts.

As an additional level of security, agency staff should sign security agreements that prohibit unauthorized disclosure of information.

Train staff on confidentiality procedures. Many child welfare agencies, alcohol and drug treatment programs, and programs for people with HIV/AIDS conduct extensive training for staffs on confidentiality procedures to ensure sensitivity to information about child abuse, alcohol and drug abuse, and HIV/AIDS status. Since some models for integrating information systems potentially make more confidential information more available, the need for regular and comprehensive training is that much greater.

Training should include:

1. the reasons for protecting the confidentiality of information about children and families;

2. the specific information the agency requires, and the reasons the agency needs the information;

3. information the worker's agency will share with other agencies, and the purposes of that information sharing;

4. the applicable legal provisions, particularly federal and state statutes and regulations;

5. the importance of fully explaining the significance of consent to clients (and staff sensitivity to family language and cultural issues), the requirements of informed consent, and the necessary elements of written releases;

6. interagency agreements, court orders, and other mechanisms that may be used by the agency to facilitate interagency information-sharing without the specific consent of clients;

7. particular considerations that arise in the context of any automated information system utilized by the agency; and

8. participation of family members in development and delivery of training.

***V.* From document entitled *Who should know what? Confidentiality and information sharing in service integration* (1993). New York, NY: National Center for Service Integration. Prepared by M.I. Solers, & C.M. Peters.**

The following is a checklist of points that agencies should consider and address in developing procedures for sharing information within and across agencies:

1. Consider the reasons for ensuring the confidentiality of information and children and families.

   The fundamental right "to be let alone" is at the root of confidentiality protections. Confidentiality restrictions protect the privacy of individuals and insure that personal information is disclosed only when necessary. The reasons for respecting the privacy of children and families include the following:

   a. Confidentiality restrictions protect embarrassing personal information from disclosure. This may include histories of emotional instability, marital conflicts, medical problems, physical or sexual abuse, alcoholism, drug use, limited education, or erratic employment.
   b. Confidentiality provisions prevent improper dissemination of information about children and families that might increase the likelihood of discrimination or harm against them even if records show that the information is unproven or inaccurate. Such information includes HIV status, mental health history, use of illegal drugs or child abuse charges.
   c. Protecting confidential information can be necessary to protect personal security. For instance, an abused woman in a domestic violence situation may be in great danger if law enforcers reveal her new location.
   d. Confidentiality provisions also protect family security. For example, many immigrant families shy away from using public health clinics or other social services for that the Immigration and Naturalization Service (INS) will take action against them.
   e. Restricting information disclosure may also protect job security. Information such as history of mental health treatment may bear no relation to job performance but could jeopardize the individual's position or ability to find employment.
   f. Children and families want to avoid prejudice or differential treatment by people such as teachers, school administrators, and service providers.
   g. Confidentiality provisions also may be necessary to encourage individuals to make use of services designed to help them. Adolescents may avoid seeking mental health services at a school-based clinic, for example, if they believe that information will get back to their teachers, parents or peers.

2. Decide on the specific information the agency needs.

In all agency functions, the information collected and recorded should be limited to the data genuinely needed to fulfill agency goals. If, for instance, the agency has a valid need for more information about the client's medical history, the agency must obtain a specific release for the medical information from the client.

3. Clarify the reasons why the agency needs the information.

Public agencies in human services and education may require children and families to share some of the most intimate and private information about themselves. They need to investigate clients to determine eligibility and appropriate assistance. But agencies should always keep in mind that the goal of obtaining information is to help provide more effective services and will not violate the rights to privacy of children and families.

4. List the information that the worker's agency will share with other agencies.

Confidentiality statutes and agency practices increasingly emphasize that workers collect, maintain, and share only the information directly relevant to the agency's purpose. More

information is not necessarily better.

5. Describe the purposes of information sharing among agencies.

While it is important to respect the need for privacy and the "right to be let alone," this right must be balanced with the needs of agencies to know about the children and families they serve in order to provide services effectively and efficiently. Oftentimes, several different systems work with the same children and families simultaneously, and both agencies and the families may benefit significantly from greater cross-system information sharing and collaboration. Reasons include the following:

a. It may be necessary to have access to information from several agencies to conduct comprehensive assessments of children and family needs.
b. Agencies also need to share information to provide all necessary services to clients.
c. Sharing information helps to coordinate service plans and avoid duplication of services. Sharing information avoids wasteful duplication, resolves conflicting demands on clients, and free resources so that agencies can provide more comprehensive care for clients.
d. Continued sharing of information will facilitate the monitoring of services by each agency.This monitoring ensures that needed services are actually provided and that agencies receive proper reimbursement for mandated services.
e. Information sharing helps to make services more family-focused. Sharing of information among agencies allows service providers to gain a broader perspective of service needs and provide the family with more appropriate services.
f. Information sharing also helps agencies reach out to serve the needs of the broader community. It can help determine the effectiveness of programs in place, current community needs that are unmet, projections of the need for services in the future, and the best ways to allocate limited resources.
g. Information sharing may also promote public safety. For instance, it helps ensure that individuals applying for licenses to operate child residential facilities have not been subjects of confirmed child abuse reports.

6. Study the applicable legal provisions, particularly federal and state statutes and regulations.

Confidentiality regulations come from a variety of sources: the U.S. Constitution, state constitutions, federal and state statutes, agency regulations, professional practice standards, and ethical standards. They may seem excessively vague or unnecessarily complicated and may dissuade professionals from sorting through them to find appropriate ways to share important information. The significant point, however is that confidentiality provisions are not absolute. All contain exceptions to their coverage or specify methods for disclosure. To fully understand a confidentiality provision, one can ask a series of questions:

a. What information is deemed confidential?
b. What information is not considered confidential?
c. What exceptions are there to the confidentiality restriction? What information sharing is authorized? Under what conditions?
d. Can information be shared with the consent of the client? What information can be released with consent? What are the requirements for a consent release? Who can give consent for information pertaining to minors?
e. Does the provision authorize other mechanisms for information sharing, such as interagency agreements or memoranda of understanding?

7. Make provisions for clearly explaining the importance of consent to clients.

Notices to clients of an agency's need to release information are critical to the process of obtaining informed consent. These notices inform clients about the purpose and the extent of the consent being requested. Inadequate and confusing notices may mislead clients and impair the relationship between clients and service providers. Clearly presented notices can inform clients of their rights and help promote trust in the agency. Generally, the client should possess sufficient knowledge of the risks and benefits of the release of information, and should

be capable of making a reasoned choice between alternatives. The person should understand what information will be disclosed, to whom it will be disclosed, the purpose of the disclosure, and the benefits of such disclosure.

8. Pay attention to the need for sensitivity to language and cultural issues.

Language and culture may compound the difficulties in obtaining informed consent. A written release of confidential information in a language not understood by the client is invalid. Some confidentiality statutes require that a notice of the consent, or the release form itself be presented in the individual's native language. Agency personnel should also be aware of different cultural customs and attitudes about privacy. Many immigrants fear that the personal information they provide may put them or their families at risk. When this issue arises, release forms should state clearly that no personal information will be given to the Immigration and Naturalization Service.

9. Develop agency or multiagency requirements for informed consent and necessary elements for written releases.

Informed consent is the most common formal mechanism for exchanging information. The individual, who is the subject of the information, gives consent generally through a signed written release. When the person is legally incompetent, because of age for instance, the parent or guardian may sign. Any release of personal information should be in writing. It should contain the following:

a. The name of the person who is the subject of the information.
b. The name of the person, program, or agency sharing the information.
c. The name of the person, program, or agency with whom the information will be shared.
d. The reasons for sharing the information.
e. The kind of information that will be shared.
f. The signature of the person who is the subject of the information.
g. The date the release is signed.
h. A statement that the release can be revoked any time by the subject of the information.
i. An expiration date for the release or a specific event (such as the end of the school year) that will terminate the release.
j. A notice stating that the subject of the information has a right to receive a copy of the release.

It is good practice to obtain written releases from clients during initial interviews or as services begin. These releases should cover routine information. Further, agencies can develop multiagency or comprehensive release forms that satisfy the confidentiality mandates of the participating agencies. By signing one release form, the client permits the participating agencies to exchange information and to coordinate services for the client.

10. Specify the role of interagency agreements, court orders, and other mechanisms that facilitate interagency information sharing without the consent of clients.

Most federal statutes permit disclosure of confidential information for a variety of administrative purposes without consent of the individual. An agency may share information for a number of reasons, including the following:

a. Administration of the program or related programs.
b. Audits.
c. Determinations of eligibility for services.
d. Medical emergencies.
e. Investigations, prosecutions, or civil or criminal proceedings related to program administration.

Authorized sharing of confidential information is common in state statutes. The statutes fall into several categories: broad authorizations for information sharing among agencies, specific authorizations regarding particular types of information (such as child abuse information), and authorizations to share information to develop more comprehensive services for children and families (such as statutes that establish multidisciplinary teams to develop treatment plans).

There are several ways to allow interagency information sharing without the consent of clients. They include:

a. Interagency agreements and memoranda of understanding
Under several federal and state statutes, agencies may enter into agreements to share information about clients to better achieve service goals. Interagency agreements should specify the following:

a.1) What information will be shared.
a.2) How the information will be shared.
a.3) Who will have access to the information.
a.4) The purposes for information sharing.
a.5) Assurances by the participating agencies that they will not disclose the information further except as dictated by the agreement, and that they will resist other efforts to obtain the information.
a.6) Other requirements mandated by applicable confidentiality provisions.

b. Court orders
These orders issued by courts allow the disclosure of juvenile court information to designated county departments to assist case planning and treatment.

c. Informal exchanges of information
The most common way of information sharing among agencies is informal, usually done verbally and by telephone. These informal exchanges frequently take place without consent or statutory authorization. However, they occur principally when people who need limited bits of information are familiar with each other and have developed a relationship of trust. If an agency participates in this form of information exchange, it should advise clients that such limited, informal information sharing may occasionally be necessary, and then determine whether the clients have objections to the practice.

The agency will be on safest legal grounds if it obtains voluntary consent, in written form, to the exchange of verbal information, and establishes clearly the types of information exchanges that will occur.

11. Review the special issues that arise from the use of automated management information systems.

When one agency's records become linked on a computer network with another agency's records for the information sharing, safeguards must be in place to assure that confidential information will not be disclosed improperly. In developing a computerized data system and using it effectively, agencies should go through the following steps:

a. Determine the purpose of the system.
Automated data management may have several purposes. Some purposes focus on the systems providing services such as researching needs for services in the community, reporting services provided by particular agencies, evaluating the effectiveness of services, assessing cost-effectiveness of services, and planning for the future. Other purposes focus on meeting the needs of individual clients which include assisting in comprehensive assessments of client needs, finding services in the community that can meet the client's needs, and tracking the cost of providing the services. Planners should determine the purposes of the system at the design stage because that decision will affect other aspects of the system - such as information accessibility, levels of security, and system usefulness to administrators, policymakers and workers.

b. Obtain the cooperation of all participating agencies.
Agencies must agree on what kind of hardware and software they will use and how they will ensure compatibility. Agencies must also agree on how to identify people in the system, what information each agency will enter into the

system, who will have access to the information in the system, how the Information may be used by participating agencies, and which security measures will be instituted to protect confidentiality and the integrity of the system.

c. Develop thorough security procedures.
Agencies should develop several levels of security to properly safeguard automated data systems:

c.1) Security of the physical environment. Data tapes and disks should remain in locked rooms when not in use. Access to these materials should be strictly controlled. Agencies should maintain logs for recording the location of all disks and tapes at all times. Access to computers tapped into the data should be strictly limited.

c.2) Security of on-line data. Agencies should limit access to the information once it is stored in the computer system. This usually involves the use of passwords. Each password allows the user to get deeper into the system, depending on his/her authorization to have that level of information. Security is maintained if each user knows only the passwords that allow access to the information that the user has a legitimate need for.

c.3) Use of identifiers to mask personal identities. Agencies should identify individuals whose information is in the system by codes such as agency-assigned identifying numbers, not by personal names. In theory, only one person knows the true identity of the person, the person who enters the information initially into the computer and assigns an identifier.

d. Train staff carefully.
The importance of staff training in this area cannot be overstated. Automated systems make so much more confidential information potentially available to so many more workers that the need for regular and comprehensive training is much greater.

e. Provide notices to clients.
Clients should receive notices stating that certain information about them is being recorded on an automated data system and that it will be accessible to others for specific purposes. The notice should specify the type of information entered into the system, the particular individuals or agencies who will have access to the information, the reasons for which they may have access to the information, and the uses they may make of the information. If the information can be shared among agencies, pursuant to a statutory provision or an interagency agreement, a general notice to this effect may be sufficient. If the information sharing requires the client's consent, the agencies could develop a common consent form that the client can sign only once.

Confidentiality and Informed Consent
Consultation Cadre List:

Note: Listing is alphabetized by Region and State as an aid so you can find and network with resources closest to you.

Our list of professionals is growing daily. Here are a few names as a beginning aid.

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Agencies, Organizations, and Advocacy

There are many agencies and organizations that offer information and guidance on ethical issues. A few are listed below.

Center for Psychology in Schools and Education (affiliated with the APA)
750 1st Street, NE
Washington, DC 20002
Phone: (202) 336-6126
Web:http://www.apa.org/ed/cpse.htm

National Center for Service Integration
154 Haven Avenue
New York, New York 10032
(212)927-8793

Center for Law and Social Policy
1616 P Street NW, Suite 450
Washington, DC 20036
(202)328-5140

Legal Action Center
153 Waverly Place
New York, NY 10014
(212)243-1313

National Center for Youth Law
114 Sansome St., Suite 900
San Francisco, CA 94104
(415)543-3307

Internet Resources Offering Assistance Related to Confidentiality

The following is a list of sites on the World Wide Web that offer information and resources related to ethics and in general and, in some cases, to confidentiality specifically. This list is not a comprehensive list, but is meant to highlight some premier resources and serve as a beginning for your search. Also, at the end of this section is a guide to using the ERIC Clearinghouses on the Internet.

The Internet is a useful tool for finding some basic resources. For a start, try using a search engine such as Yahoo and typing in the words "ethics" or "confidentiality" and "school mental health". Frequently if you find one useful Webpage it will have links to other organizations with similar topics of research.

Listed below are some Websites that contain information related to ethics:

American School Counselor Association (ASCA)
Address: http://206.25.246.16/asca/
Description: This homepage gives you access to counseling-relevant information including listings of periodicals, links to other school counseling resources, and a discussion on ethics. Phone: (800) 306-4722.

Mental Health Education Page -- Confidentiality
Address: http://www.metrolink.net/~jquimby/confid.htm
Description: This offshoot of the Mental Health Education Page contains a brief article on confidentiality.

The Institute of Law, Psychiatry, and Public Policy (University of Virginia)
Address: http://ness.sys.virginia.edu/ilppp
Description: Contains information about training programs and seminars on mental health practice, social policy, and the law. One course (click on "Civil Training Programs") deals specifically with confidentiality. Phone: (804) 924-5435.

Health Hippo
Address: http://www.winternet.com/~hippo/hippohome.html
Description: "A collection of policy and regulatory materials related to health care" (from the site). Includes links to various search engines, including those related to health and the law.

PsychScapes WorldWide, Inc.
Address: http://www.mental-health.com/PsychScapes/ethical_guidelines.html
Offers a review of paraphrased excerpts from the ethical guidelines and/or standards of practice from various mental health sources.

AskERIC
AskERIC is a very useful Internet resource that allows you to search the ERIC Clearinghouse. On the following page is a guide to using AskERIC. For a discussion of the ERIC Clearinghouses, see the reference section of this introductory packet.

An Example of an ERIC Digest

Ethical and Legal Issues in School Counseling

INTRODUCTION

School counselors often ask questions such as, "What should I have done in that situation?" or "Did I do the right thing?" This desire for information and feedback regarding difficult cases was reiterated by respondents to a Membership Survey conducted by the American School Counselor Association (ASCA) in 1988, wherein the need for ethics information was ranked among the top concerns. Why are we seeing this ongoing interest in ethical and legal issues? Why are we seeing an increase in the literature in these areas? It is hoped that the counseling profession as a whole is becoming more aware of, and sensitive to, the need for ethical practice; that is, the importance of practicing ethically within the law. Perhaps the increase in litigation involving educators and mental health practitioners is a factor. Certainly the laws are changing or at least are being interpreted differently, requiring counselors to stay up- to-date. The process of decision-making and some of the more complex issues in ethical and legal areas are summarized in this digest.

Ethical decisions are usually not clear-cut; they tend to be in the "gray areas" rather than in "black and white." Furthermore, the "right" answer in one situation is not necessarily the "right" answer in a similar case at another time. As society changes, the issues change; and, indeed, as counselors change, their perspectives change. If we understand and accept the fact that ultimately counselors will have to struggle with themselves to determine the appropriate action in each situation, then we realize the importance of ethical and legal awareness and sensitivity. We then also understand the need for periodic re-examination of the issues throughout our professional lives (Huey & Remley, 1988).

ETHICAL STANDARDS

The importance of knowing the contents of professional codes of conduct and the purposes and limitations of such codes is essential to the understanding of ethical and legal issues in school counseling. Although detailed memorization of the ethical codes is not required, school counselors should have at least a basic understanding of their ethical responsibilities as defined in these documents (Huey, 1987).

The ethical standards of ASCA and the American Association for Counseling and Development (AACD) present school counselors with the behaviors to which they should aspire and give general guidelines for addressing difficult issues. They do not, however, necessarily provide answers to the many specific dilemmas that practitioners will face. When the standards do not provide enough direction, counselors are encouraged to consult with colleagues, professional experts, and perhaps their administrative supervisors before taking action.

Almost all professionals, at some point in their career, suspect or become aware of a colleague's unethical behavior. School counselors are obligated to address any conduct by a colleague that could cause harm to clients. Counselors should: (a) try to resolve the issue by confronting the colleague directly, if possible; (b) report the behavior to a superior, professional association, or credentialing authority if a direct confrontation is not possible or is not effective; and (c) take steps to protect any vulnerable clients.

PRIVACY, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION

Confidentiality and privileged communication are two related issues that school counselors often confuse. Information clients relate to school counselors should be kept confidential with the following general exceptions: (a) the client is a danger to self or others; (b) the client or parent requests that information be related to a third party; or, (c) a court orders a counselor to disclose information.

Although all school counselors have a confidentiality responsibility, very few relationships with students are considered privileged. Privileged communication is granted only by statute and guarantees clients that a court cannot compel a counselor to disclose information related in confidence. Such statutory privileges belong to clients rather than to counselors, and most states do not grant privileged communication in school counseling relationships.

LEGAL ISSUES

Legal standards of practice are different from ethical standards. Generally, legal standards are related to

accepted professional practices in the community while ethical standards tend to be idealistic.

Many schools have policies that differentiate between the rights of custodial and noncustodial parents, and school counselors are often required to implement such policies. The law is clear that, barring a specific court order to the contrary, noncustodial parents have all rights regarding their children except the right to have custody of the children permanently in their homes.

When federal legislation known as the 1978 Hatch Amendment was passed and revised regulations were issued in 1984, a great deal of misinterpretation occurred that inhibited the offering of school counseling services. Eventually it was realized that the amendment's requirement of written parental consent for children to participate in certain school programs covered only a narrow range of activities that were federally funded, were experimental in nature, and involved psychological tests or treatment.

School counselors often play a major role in administering the school's testing program. School counselors should provide expert advice to school policymakers regarding the appropriate use of tests. Counselors should assist in evaluating each test to determine whether it: (1) discriminates in any way against any segment of the school population, (2) is valid and reliable, (3) is appropriate for the purposes for which it is being used, and (4) is necessary to achieve the school's objectives. Moreover, the counselor is responsible for interpreting test results for students in a clear and understandable manner.

The laws regarding abortions for minors are changing (Talbutt, 1983). Generally, school counselors may discuss a student's decision of whether to seek an abortion with the student, but they should also encourage parental involvement when possible. Each case must be decided individually based on the facts as presented.

THE SCHOOL COUNSELOR AND CHILD ABUSE

In most states, school counselors are obligated to report suspected cases of child abuse. While the mandate is clear, issues must be resolved such as appropriate reporting procedures, relationships with investigators and prosecutors, and appropriate interactions with the family.

ETHICAL ISSUES IN GROUP WORK

Group counseling presents ethical issues not found in individual interventions with clients. The advantages of a comprehensive group counseling program are numerous; however, school counselors who direct such programs need to be familiar with potential ethical problems.

Although group counseling in general presents special problems, providing group counseling for children introduces issues not found when working with adults. Although the ASCA Ethical Standards for School Counselors (1984) does not directly address group counseling, some specific guidelines are found in the AACD Ethical Standards (1988). The ASGW Ethical Guidelines for Group Counselors (1989) provides additional direction.

SPECIAL ISSUES

Computers. School counseling offices are increasingly utilizing computers and computer products. School counselors have made attempts to understand and utilize this modern technology, but many counselors are still unaware of the ethical issues involved in the use of computers. It is imperative that professional associations develop ethical standards regarding computer use. Moreover, the importance of direct counselor-client contact in conjunction with the use of computers must be stressed.

Cultural diversity. School counselors have a responsibility to provide services for all students, including those from other cultures. The counseling profession is a Western culture phenomenon; however, school counselors constantly interact with families and children who speak languages other than English, adhere to values different from those of the counselor, and conform to social expectations that may seem odd to the American school environment. The unique ethical issues involved in counseling multi-cultural populations need to be addressed.

Research. There is an increasing demand for school counselors to engage in field-based research. Documenting program effectiveness can do more to promote school counseling than all public relations efforts combined. But even if school counselors never conduct research themselves, they need to know the rights of students involved in research projects, the responsibilities of researchers, and other research-related ethical issues.

Sexual intimacy. Perhaps the most pressing ethical problem in the counseling profession is sexual intimac with clients. School counselors are involved less often in sexual relationships with clients than are their

colleagues who counsel adults. Nevertheless, clients, no matter what their age, often introduce sexual dimensions into the counseling relationship. Counselors who are faced with sex and intimacy boundary issues in their professional counseling roles must respond in a manner that is consistent with ethical guidelines.

CONCLUSION

An interactive dialogue about ethical dilemmas generally provides the best framework for learning and professional growth (Larrabee & Terres, 1985). State departments of education, local school systems, and counselor education departments are strongly encouraged to offer courses, workshops, and programs on ethical and legal issues. The ASCA Ethics Committee is available as a resource to help plan and implement such programs. Inquiries should be addressed to the ASCA Ethics Committee, American School Counselor Association, 5999 Stevenson Avenue, Alexandria, VA 22304.

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OVERCOMING CONFIDENTIALITY BARRIERS IN HUMAN SERVICES COLLABORATION FOR AT-RISK YOUTH

(William E. Davis, Ph.D.*)

The 1990s have witnessed a rapidly growing movement throughout our nation to develop more effective collaboration among all major human service agencies which serve at-risk children, youth, and their families (Center for the Study of Social Policy, 1993; Davis, 1993; Dryfoos, 1994; Melaville, Blank, & Asayesh, 1993; Morrill, 1993). The current human services delivery system has been widely criticized as being too narrowly focused, fragmented, crisis-oriented, and largely inaccessible (Blank & Lombardi, 1991; Gardner, 1992; Hodgkinson, 1992, 1993; Kagan, 1991; Morrill, 1992, 1993; Weissbourd, 1991).

Proponents of integrated services generally believe that poor education, health, and social outcomes for children result, in large part, because the current human services systems are not able to respond in a timely, coordinated, and comprehensive fashion to the multiple, complex, and often interconnected needs of a child and his or her family. Many health, education, and social service programs today often proceed from an -implicit preference for remediation rather than prevention, and from the framework of family and neighborhood deficits rather than strengths. Further, many of today's programs and delivery systems do least well for those families with the greatest needs - those with multiple problems (Morrill, 1993).

Information Sharing and Confidentiality

A central goal of service integration programs is to coordinate the efforts of several agencies that are working with the same child and/or family. In most instances, this effort requires the sharing of information among the respective agencies. While on occasion participating agencies need only aggregate information, usually agencies need to share personal information about a particular child and family. Laws protecting the confidentiality of such information collected about children and their families frequently create substantial obstacles to the information sharing process (Larson, 1993).

Clearly, confidentiality mandates are very important and they need to be upheld. They have been developed to protect basic rights to privacy which all service providers must closely guard and carefully respect. Also, it must be recognized that in addition to governmental legal requirements, most professional disciplines have legal obligations or strong ethical standards that prohibit release of information about a client, patient, or student without consent (Greenberg, Levy, & Palaich, 1992).

Confidentiality requirements involving interagency collaboration certainly are not new. However, as Greenberg, Levy, and Palaich (1992) suggest, what is new is that in the current environment there exists a growing expectation that organizations routinely will work together to help children and families. Put into practice, this expectation has several implications in the area of information sharing: it means that an exchange of information is likely to be sought in substantially more cases, that more organizations are likely to be involved in the exchange, and that more detailed information is likely to be desired. In brief, questions that once rarely were asked about vulnerable children and families are now far more likely to be commonplace.

As interagency collaboration efforts gain momentum, service providers from education, mental health, child welfare, and health agencies increasingly find themselves in a very delicate *dilemma*. Program staff recognize the need to

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maximize the flow of information with the least amount of bureaucratic procedures. At the same time, nevertheless, their knowledge that law and good practice preclude open exchange of this information without the proper regard for clients' rights usually represents an even stronger conviction (Hobbs, 1991).

Sources of Confidentiality Requirements

Individual agencies which work with at-risk youth and families typically are guided by a series of confidentiality requirements which pertain specifically to their mandated professional mission and orientation. Confidentiality requirements, however, often are derived from broader sources.

Following is a brief description of the major sources of confidentiality requirements which affect providers in agencies involved in human services collaboration efforts (Larson, 1992, p. 132).

Constitutional Roots

Both the United States Supreme Court and several state constitutions contain explicit provisions regarding matters of individual privacy. The privacy rights of minors, in particular, have been examined by courts, and judicial decisions rendered on their behalf in such matters as reproductive decision making and the confidentiality of juvenile court records must be considered by agency service providers.

Federal Statutes

A large share of health, education, and social services provided to children and families are paid for, at least in part, by federal funds. For states and local communities to receive this funding, they must comply with the requirements specified in the federal statutory law authorizing the funding. Usually, one of these requirements is that any records maintained by agencies involving the identification of recipients of services be kept confidential.

State Statues

Many states have specific statutes which address child and family information sharing among agencies. In many states, these laws essentially follow federal guidelines. However, some states have extremely restrictive confidentiality requirements related to client information sharing. With the recent call for increased collaboration among state agencies to more effectively serve children and families, it is essential that program administrators and service providers carefully check the various state codes involving confidentiality which exist within their own state.

Local and Agency Regulations

In addition to the need to be aware of federal and state confidently requirements, service providers interested in developing interagency collaborative programs for children and families often find themselves having to deal with local and county agency confidently provisions and regulations. In some states, these requirements can be extremely restrictive, far exceeding those established in related federal or state statues.

Professional Standards

Each of the major agencies which is typically involved in efforts to develop a more comprehensive and integrated human services delivery system is comprised of professionals who often represent different disciplines. Each of these disciplines, e.g., psychology, social work, and medicine, has its own code of ethics and specific licensing laws. Clearly, all professionals are bound to adhere their individual discipline's code of ethics and licensing regulations. At times, professionals are unwilling and/or unable to share client information with

representatives of other disciplines, citing potential "code of ethics" or "licensing" violations as the reason.

Strategies for Overcoming Confidentiality Requirement Obstacles

Despite generally widespread agreement among service providers from all major agencies involved with children and families that the current overall human services delivery system is inefficient, ineffective, and badly in need of a major overhaul, and further that their clients would benefit from increased interagency collaboration efforts, potential collaborators often conclude that confidentiality requirements make it impossible to proceed with a joint initiative (Greenberg, Levy, &. Palaich, 1992).

Clearly, perceived confidentiality barriers frequently can serve as a major deterrent to effective interagency collaboration. Some professionals never appear able to move beyond this perceived barrier. Interestingly, some observers suggest that confidentiality requirements are "proving to be more of a 'red herring' than a real obstacle to system change and that most communities are finding ways to protect client rights while providing front-line workers with the capability to share information that will enable them to be more effective in helping clients" (Blank, 1992, p. 21).

As clearly stated by Greenberg, Levy, and Palaich (1992), confidentiality requirements should not be looked upon as either an impenetrable barrier nor as something which can be casually disregarded. Based upon the experiences of practitioners who have dealt successfully with confidentiality requirements, as well their own analysis of this issue, these authors conclude that it is possible to develop means of exchanging information that are effective and practical on a wide scale, while still respecting legitimate rights to privacy (pp. 1-2).

Following are selected guidelines, cautions, and specific strategies which have been demonstrated as being effective in helping to overcome some of the most common confidentiality requirement obstacles. It cannot be emphasized enough that confidentiality rules and provisions are absolutely critical to maintain. The basic purpose of their existence is to "protect individuals from unwarranted invasions of their privacy and from use of information for a purpose for which it was never intended" (Greenberg, Levy, & Palaich, 1992, p. 5).

Nevertheless, the sharing of important information among service providers is essential to the success of any human service interagency collaboration efforts. The following strategies are presented to help potential collaborators deal with some of the most basic confidentiality requirement issues which often serve as unnecessary barriers to the development of an effective, integrated, human services delivery system.

Clarify Why Information Sharing Is Important

While it may appear obvious, the reasons why information sharing among service providers is necessary may need to be clarified at the very outset of the collaboration process. Frequently, service providers have become so consumed with the specific needs of their clients and the particular interventions that their agencies offer that they fail to see the need for information sharing with service providers from other agencies.

Most professionals have developed a very narrow perspective relative to the overall needs that a child or family member may have. They tend to view and treat the specific problem which is presented in the narrow context of their own particular discipline. True collaboration calls for the sharing of relevant information to ensure that the holistic needs of children and their families are met.

Information sharing is important for several reasons. It helps ensure that the services being provided are comprehensive and continuous. Often, the same individual may be a client of many agencies at the same time. Unnecessary

duplication of services frequently results. At other times, current gaps in services caused by clients entering, leaving, and then re-entering programs can be alleviated by the exchange of information among service providers from the respective agencies involved.

Information sharing also is critical to avoid the common situation of clients receiving very fragmented services. It may be that some clients will require intensive interventions over a brief period of time. Yet, this frequently does not occur because the client with multiple problems is being seen by several different agencies, each of which is providing only very basic and limited interventions. Information sharing can assist in the focusing of interventions which are more likely to result in the most positive outcomes. There is greater likelihood that treatment priorities across and within disciplines can be established by the very fact that service providers from different agencies are more aware of what "everyone else is doing with the client."

Finally, the value of good information sharing is that it "flows both ways." A service provider may gain valuable insights and information from others who are involved with his/her client -- insights and information which may prove to be very beneficial in his/her own interactions with the client. These would not have been available if it were not for interagency information sharing.

Proceed Cautiously and Lay the Groundwork

Service providers who are interested in developing effective collaboration with professionals from other agencies and disciplines often make a serious mistake at the very beginning of the collaboration process. They begin with a discussion of confidentiality requirements which are assumed to pose potential barriers to the overall process.

In this regard, Greenberg, Levy, and Palaich (1992) state, "Perhaps the clearest advice we heard from successful collaborators is that working on confidentiality and information sharing should not be among the first tasks of a developing collaborative effort. Because the subject is complex and a mutually agreed upon approach for information is likely to entail compromises, it is important to have working relationships and commitment to joint efforts already in place" (p. 7).

Confidentiality requirements typically represent a "hot button" issue. Some individuals will automatically rule out any potential benefits of interagency collaboration because they sincerely feel that their profession's code of ethics or licensing requirements would preclude the sharing of any of their clients' confidential information with other service providers outside of their profession. It usually takes a considerable amount of time to develop trust.

Potential collaborators from different disciplines/agencies need to feel comfortable not only with each other as professionals but also they need to feel comfortable in the "sharing of a common vision or mission" with all others involved in the process. To begin with a discussion of confidentiality requirements will likely only serve to work against the consensus building which is essential for the success of interagency collaboration (Melaville, Blank, & Asayesh, 1993).

Very simply, this issue is too hot! Clearly, this issue will need to be addressed fully at some point in the collaboration planning process. It is too critical to ignore. Yet, allow sufficient time for individuals to develop a basic level of mutual trust before tackling the delicate issue of confidentiality requirements. This strategy is very similar to that frequently offered to persons who approach school boards with the objective of starting of a school-based health clinic for students. Should the discussion of this issue begin with the need for services for gay, lesbian, and bisexual youth, or with the need for abortion counseling - one can be almost assured that, in most communities, the health clinic will never be established. Again, these are hot button issues, and for many individuals, they find it impossible to get beyond them.

Determine Who Should Be Involved And What Should Be Shared

Once it is clear that information sharing among various agency service providers is essential, decisions must be made relative to issues of (1) who should be involved in this process, and (2) what specific information needs to be shared. In making these choices, Greenberg, Levy, and Palaich (1992) suggest that "a balance must be struck between involving all those who are potential stakeholders or who could make a significant contribution and keeping the group from becoming unwieldy" (p. 7).

In addition to staff members who are specifically charged to develop policy and procedures for interagency information sharing, others whose participation might be helpful in this process normally include cabinet level officials; line managers and staff; parents, clients; and child/family advocates; legislative staff, judges; management information system personnel; and attorneys (Greenberg, Levy, & Palaich, 1992).

Determining what specific information about a client which needs to be shared among the potential stakeholders, however, generally is a more difficult task. It is clear that not all stakeholders need to or should know all details about a client. For example, a psychologist would be in violation of his/her profession's code of ethics to share certain information about a client which was obtained within traditional assessment and therapeutic milieus. Essentially, such information rightfully is considered privileged and confidential. Further, much of this information, in most cases, would likely be of limited value to others anyway.

Nevertheless, it may be very important that service providers from other agencies know, at the very least, that one of their clients currently is receiving services from another agency. This often is not the case. There may be some information that a psychologist possesses about a client which not only would be very valuable for professionals from other agencies to know about, but also this information may be of such a nature that the particular psychologist would want to share with others -- if only he or she knew who else might be interested in such.

Simply by service providers agreeing to share nothing more than the names of other professionals who presently are involved with "common clients" can have benefits. Calls can be made to those individuals to seek any information which could be made available. It then would be the responsibility of each involved professional to make a judgment relative to which information, if any, would be appropriate and potentially helpful to share.

The reality is that all too often individual clients who have multiple problems and who are involved with multiple agencies simultaneously do not receive overall effective and efficient services because potentially important information is not being sufficiently shared among professionals. For professionals not to share certain client information, claiming that this would violate confidentiality requirements, may, at times, not only be inaccurate, but also it could serve to prevent clients from receiving valuable service which they require.

Increasingly, individuals who have been involved in the development of human services collaborative efforts have come to the conclusion that, in most cases, the issue of confidentiality requirements is not the major obstacle which it is often thought to be. It has been demonstrated that if professionals truly are committed to the development of a more integrated human services delivery system for children and families, decisions regarding who should share what information with whom can be made with relative ease.

Legislative and Legal Solutions

One of the most commonly cited obstacles to the development of an effective human services delivery system is that current statutes generally

preclude the sharing of client information among agencies, and further that it would be too difficult to make changes in existing laws. However, citing recent studies which addressed this issue, Melaville, Blank, and Asayesh (1993) indicate that statutory changes rarely need to be obtained because sufficient overlap exists in each service provider's agency confidentiality rules to allow them to share information while fully protecting families' rights and welfare.

A thorough review of applicable and potentially applicable statutes, regulations, constitutional provisions, and relevant court decisions is necessary. And, as recommended by Greenberg, Levy, and Palaich (1992) it is important to extend this review beyond the statutory confidentiality provisions and associated rules because sometimes courts interpret the language of a statute or regulation in ways that might be surprising given the language of the provision. Finally, "because court rulings may also create additional 'law' governing confidentiality ... it is essential to look at court decisions as well as statutes and regulations when deciding what is and is not permissible" (Greenberg, Levy, & Palaich, 1992, p. 9).

At times, it may be necessary to seek changes in existing laws to allow information sharing among agencies as related to specific programs or projects. In California, for example, "a statute authorizes information sharing among interdisciplinary teams established to prevent, identify, or treat abused children; while another statute sets parameters for information sharing among members of interagency council established as part of a mental health demonstration project" (Larson, 1992, p. 133).

Obtaining "Informed Consent" and Developing "Common Release Forms"

The most common approach to satisfying confidentiality protections is obtaining "informed consent." Generally all major agencies involved with children and families already have in place informed consent policies and procedures which reflect common principles: consent must be given voluntary; the individual must fully understand what information will be shared, with whom it will be shared, and specifically how this information will be used; and that any consent must be documented in writing, most often on a signed release form.

However, despite the commonalty which exists in principle among most agency informed consent policies and practices, what complicates this issue is that each individual agency is likely to be responding to a different governing statute and to have a different set of rules about consent (Greenberg, Levy, & Palaich, 1992). Laws relative to what specific information may be released among agencies often are very vague, leading to a great deal of "local interpretation." Also, major inconsistencies often exist among the actual forms used to obtain informed consent.

Potential collaborators will need to confront and likely compromise on several issues involving informed consent. The multiple and varied confidentiality requirements among the policies, practices, and forms among agencies will need to be accommodated so that two major objectives will be accomplished: (1) all agency service providers will feel "comfortable" with the new, unified system and (2) the essential protections for children and families which existed under previous individual agency policies and practices are the same -- or, improved.

Although initially it may appear to represent an "overwhelming" task, the development of a single, common release form has several advantages. First, a common release which all agencies agree to use generally eliminates confusion on the part of service providers within individual agencies regarding whether or not it is "appropriate" to release certain information to other service providers in other agencies.

Second, service providers often discover that by engaging in the process of developing a common release form, much client information which previously was routinely collected, may indeed be superfluous and unnecessary. A common

release form may result in a much more streamlined and effective way of obtaining informed consent. Third, a common release form typically makes it much easier for clients to obtain services. It avoids their need to fill out multiple and often duplicative forms.

As stated by Greenberg, Levy, and Palaich (1992), a basic principle for developing release forms is to avoid "blanket releases" which are completely open-ended on matters like the time period covered, the information to be exchanged, and the reasons for the exchange. Blanket releases not only are the most likely to be troubling to the individual from whom consent is being sought but also they generally are the most legally vulnerable.

In the development of common release forms, it is critical that potential interagency collaborators pay strict attention to not only the specific language which is contained therein (e.g., is it clearly understandable culturally/linguistically sensitive) but also to the specific content which they contain. If a single release form is to be used by several agencies it is important that agreement be obtained regarding several content issues.

Among the most salient content issues which must be addressed by agencies pursuing the development of a single, common release form are the following: provisions for limiting consent; a clarification of specifically who is covered by the release (e.g., if a parent is signing for family members, what constitutes "family"?); limits, if any, to the type and scope of the information to be released (e.g., oral, written or both; all information which an agency possesses on a client or only partial information); the purpose for which information will be used and under what circumstances; termination dates; suggested benefits of information sharing; and whether or not a statement should be included which specifies any consequences of not authorizing release (Greenberg, Levy, & Palaich, 1992, pp.16-17).

While the development of a single, common release form clearly needs to be adapted to the regulations and provisions of those specific agencies involved in the collaborative effort, readers may be interested in reviewing common release forms which have been employed successfully by several human services collaboratives. Several of these "sample forms" are contained in Confidentiality and Collaboration: Information Sharing in Interagency Efforts (Greenberg, Levy, & Palaich, 1992, pp. 35-44).

Conclusion

It has become very clear that our nation's current overall human services delivery system for children and families is woefully inefficient and ineffective. The bottom line is that needed services are not being provided to these individuals in sufficient quality or quantity. Further, even in those situations where services are being provided to this heterogeneous population, they often are extremely fragmented, episodic, and lacking in easy accessibility.

Large and growing numbers of children and families are being recognized as having multiple problems which frequently are interconnected but which are being treated in isolation at the same time by several different agencies. Calls for the development of a more integrated human services delivery system through increased interagency collaboration efforts to help remedy this problem have been commonplace during the late 1980s and 1990s. One of the most commonly cited obstacles to interagency collaboration efforts, however, has been the belief that *confidentiality requirements* generally preclude the development and implementation of effective system .

A review of the literature related to confidentiality requirements as potential barriers to information sharing among agencies suggests that concerns about protecting client confidentiality, as important as they are, need not necessarily constitute the impenetrable obstacle to effective collaboration which they are often thought to be. Service providers who are interested in developing more effective interagency collaboration to better serve their clients should not be discouraged from pursuing this objective, fearing that confidentiality restrictions

will prevent this from happening.

Service providers need to be fully aware of the several sources of confidentiality requirements which must be respected and certainly not to be disregarded. However, they also need to become familiar with several strategies which have been demonstrated as being effective in overcoming common obstacles which are related to the complex issues involved in client confidentiality.

The major intent of this paper has not been to suggest that service providers should seek methods whereby they can circumvent client confidentiality requirements. This suggestion would be indefensible on several levels. Rather, it is argued that the full protection of client confidently rights can be maintained while working toward the development of a more effective and integrated human services delivery system. This will require a great deal of hard work, flexibility, a willingness to compromise, and a large dosage of mutual professional trust. However, it is suggested that this endeavor is well worth the effort if it results in vulnerable children and families receiving easier access to quality, comprehensive services.

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This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

CLEARINGHOUSE CATEGORIES

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Other System Topics: _____
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

Programs and Process Concerns:

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics
- Other program and process concerns: _____

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning Problems
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness
- School Adjustment (including newcomer acculturation)
- Other Psychosocial problems: _____